Patient Information

Name_____

Title Dr. Mr. Mrs. Ms. Minor (circle one)

Address_____

City_____**State**_____**Zip**_____

Date of Birth_____**Age**_____

SS# _____

Occupation_____

Mobile#_____

Work#_____

Email_____

RESPONSIBLE PARTY

Relation Self Spouse Parent (circle one)

Name_____

PRIMARY INSURANCE INFORMATION

Name of Insured _____

Relation Self Spouse Parent (circle one)

SS# of Insured _____

DOB of Insured _____

Subscriber ID#_____

Carrier/Company_____

Employer_____

Group Policy#_____

(We will provide you with codes to file for secondary insurance, but we don't process secondary insurance)

Dental History

Is there anything you would like to speak with the doctor about in private? Y N

Have you ever had excessive bleeding requiring special treatment? Y N

Have you been hospitalized or had major surgery within the past two years? Y N

Do you have any Prosthetics/Joint Replacements? Y N

Are there any sores or any growths in your mouth now? Y N

Have you been told you have gum problems? Y N

Have you ever seen a (gum specialist) periodontist? Y N

Have you ever had a bad experience in a dental office? Y N

Do you feel nervous about having dental treatment? Y N

Is there anything you dislike about your smile? Y N

If yes what is it?

_____

How did you hear about us?

_____

Signature_____

Date_____

Camenzuli DENTAL EXCELLENCE

HEALTH HISTORY

Have you had a change in your health since your last visit? NO YES

Have you been hospitalized or had major surgery since your last visit? NO YES

Please explain if answered yes?_____

Date of last health care exam: _____What was this exam for?_____

Please list all the Names of the physicians who are currently providing you care:

1. _____2._____

For the following questions kindly circle yes or no.

Heart Murmur (mitral valve prolapse)	No	Yes	Psychosis	No	Yes
Anemia	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form	No	Yes	**Cancer**	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	**Joint Replacement**	No	Yes
HIV Positive or AIDS Related	No	Yes	Glaucoma	No	Yes
Emphysema or Bronchitis	No	Yes	Abnormal Bleeding from a cut	No	Yes
Abnormal Heart Condition	No	Yes	Liver Disease (Jaundice)	No	Yes
Kidney Disease	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart (Surgery, Disease, Attack)	No	Yes	Latex Sensitivity	No	Yes
Venereal or Sex Transmitted Disease	No	Yes	Other infections	No	Yes
High Blood Pressure	No	Yes	**MY normal Blood Pressure is**		

Are you taking any of these medications?

Aspirin,Coumadin,Plavix(**bloodthinner**)?	No	Yes	Dialysis?	No	Yes
Antacids?	No	Yes	Bisphosphonates?(osteoporosis)	No	Yes
Chemotherapy?	No	Yes	Recreational Drugs?	No	Yes
Do you use **Tobacco**? What Form? How Much?				No	Yes
Please list any **Herbal Supplements**				No	Yes

Please list any medications you are currently taking: (attach list if necessary)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Do you have any drug allergies? NO YES Please List: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I am ultimately responsible for notifying the doctor of change in my health and medication. This information is for internal use only and will be held private.

_____ _____ _____ _____

Signature ***Print Name*** ***Date*** ***Dentist Initials***

Patient Authorization for Use and Disclosure of Protected Health Information

Camenzuli Dental Excellence

By signing, I authorize **Camenzuli** Dental Excellence to use and/or disclose certain protected health information (PHI) about me to insurance companies and specialist's referral and consultation.

This authorization permits Camenzuli Dental Excellence to use and/or disclose the following individually identifiable health information about me, X-rays, photographs, clinical notes, procedure notes, and diagnostic opinions.

The information will be used or disclosed for the possible following purposes: at the request of the individual, as requested from insurance companies, as requested from specialist referred to.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on written notice from patient.

Camenzuli Dental Excellence will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Camenzuli Dental Excellence In fact; I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization, **or if you intend to file your own claims with insurance companies.** My written revocation must be submitted to the privacy officer at: When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Camenzuli Dental Excellence, 1319 Amelia Street New Orleans, LA 70115

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

First Name: Last Name:

I understand that, under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Relationship to the patient: Self Parent Guardian

Name if not the patient:

Signature X _____

Date: _____

Insurance assignment and Financial Consent

We welcome you and your family to Camenzuli Dental Excellence, the office of Dr. Robert Camenzuli D.D.S. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office and financial policy consent. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your treatment as much as possible.

Dental and Medical Insurances

If you have insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patient's responsibility to update Camenzuli Dental Excellence at the earliest convenience. While we do our best to verify benefits at your first appointment, this does not guarantee coverage or payments to Camenzuli Dental Excellence. We do accept payments/assignments of benefits from the insurance companies.

Camenzuli Dental Excellence will provide you with an ESTIMATE of your out of pocket expense for any treatment planned by the doctor(s). However, please understand that these are strictly estimates and are <u>not a guarantee that your insurance company will reimburse us/you according to these estimates</u>. Pre-authorization are not a guarantee of payment.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 60 days from the date of service becomes the immediate responsibility of the patient and/ or responsible party

Cancellations and Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 48 hour cancellation notice. Your scheduled time has been saved only for you and the doctor and/or hygienist. Due to staff overhead that occurs in broken appointment slots, a cancellation fee of $35 for cleaning appointments, and $75 for treatment appointments may be charged if a 48 hour notice is not given. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and pre scheduled availability for you, and are very forgiving of extenuating circumstances

Insurance assignment and Financial Consent

Account Balances / Charges

Returned checks and balances older than 90 days will be subject to an additional billing charge of $35.00. Any balance older than 90 days will be subject to interest charges of 1.5% per month until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency and additional collection fees will be applied to any unpaid balance. Any attorney or collections fees incurred due to delinquency in payment will also be charged to the patient. We do understand that temporary financial problems may affect timely payment of your account. If this is a concern, we do ask that you contact us promptly for assistance in the management of your account.

Payment / Copays / Deductibles

Payment for full services, co-pays, and/or deductibles is due at the time services are provided. We have several options for payment of services, which may be paid in the following manner:

1. Payment by Cash, Check, Visa, MasterCard, Discover or American Express
2. Payment by Care Credit. Care Credit is bank financing for qualified applicants who prefer additional time to pay their balance. It is a revolving line of credit through an independent financial institution. It is designed to meet the needs our patients and is ideal for extended treatment plans, elective procedures, emergency care, and treatment not covered by insurance. Care Credit has financing options available that include 3, 6 and 12 month interest free payment plans, as well as an extended payment plan with interest rate.

- I understand my payment options, and that payment for services is due at time services are rendered.
- I understand that any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $35 NSF check fee to absorb bank charges to our office.
- I understand that if my account becomes delinquent then late charges, finance fees, and any collections costs will be added to balance.
- I understand the above paragraph regarding potential cancellation fees.
- I understand I am responsible for all charges not covered or outside of my dental insurance.
- I understand the above paragraph regarding dental insurance, and I hereby authorize my insurance company to pay directly Camenzuli Dental Excellence all dental benefits due to me.
- I have had the opportunity to have any questions answered to the best of Camenzuli Dental Excellence's ability. A copy of this consent is available for you by request.

Signature(ResponsibleParty)_____PrintName_____Date_____

Consent to Electronic Communications via Email

First Name: Last Name:

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties.

However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

[ ] I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

[ ] I consent only to receiving appointment and recall reminders via email. I understand I can withdraw my consent at any time

[ ] I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Patient's Signature X_____

Date: _____

Consent to Perform Preventive Dentistry

Patient Name: _____

Date: _____

I hereby authorize and direct the dentists of Camenzuli Dental Excellence to perform the following dental treatment, including the use of any necessary radiographs (x-rays) or diagnostic aids. These procedures include, but are not limited to examinations, oral prophylaxes (above the gum line cleanings), fluoride treatments, photos, & impressions for study models.

Patient's signature X_____

Date: _____