Forest Park Dental
Eric J. Aubert DMD PC
4527 Forest Park Dental
St. Louis, MO 63108
314-367-7200

Patient Information

Patient Name:______________________________ Date:____________ ☐Male ☐Female

☐Married ☐single ☐Child ☐ Other_______ Birth Date______________ Social Security______________

Cell Phone# ________________ Home Phone# ______________ Work phone# ______________

Email:____

Address:____
Street Apt # City State Zip code

Health History

Date of Last Dental Visit:_________ Reason For Visit:______________________________

Have you ever had any of the following? Please Check all that apply:

Aids/HIV___ Allergies______________________ Arthritis___ Artificial Joints___ Asthma___ Blood Disease___ Cancer___

Diabetes___ Dizziness___ Epilepsy___ Excessive Bleeding___ Fainting___ Glaucoma___ Growths___ Hay Fever___

Head Injuries___ Heart Disease___ Heart Murmur___ Hepatitis___ Type______ High Blood Pressure___ Jaundice___ Kidney

Disease___ Liver Disease___ Mental Disorders___ Nervous Disorders___ Pacemaker___ Pregnancy___ Due Date___________

Radiation Treatment___ Respiratory Problems___ Rheumatic Fever___ Rheumatism___ Sinus Problems___ MVP___

Stomach Problems___ Stroke___ Tuberculosis___ Tumors___ Ulcers___ Venereal Disease___ Codeine Allergy___ Penicillin Allergy___

Other______________________

1.Have you ever had any complications following dental treatment? ☐YES ☐NO
If yes, please explain:______________________________________

2. Have you ever been admitted to a hospital or needed emergency care in the past two years?
☐YES ☐NO If so please explain:______________________________________

3. Are you under the care of a physician? ☐YES ☐NO Name of Physician:____________________

4. Do you have any health problems that need further clarification? If so, please explain:

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at my next appointment without fail.

Signature:______________________________________ Date:______________

How did you hear about our office? Google ☐ Current Patient ☐ Billboard ☐ Yelp ☐ Yellow Page ☐

Dental Office ☐ Other ☐ ________________________________

Insurance Subscriber Information

Parent ☐ Spouse ☐ Guardian ☐ Name________________________ __________ Male ☐ Female ☐

Married ☐ Single ☐ Other ☐ ______ Birth Date______________ Social Security Number________________

Cell phone #________________ Work phone #________________ Home Phone #________________

Address____
Street Apt # City State zip code

If Married, and both of patients of record, would you like to have a family account or a private account?

Family ☐ Individual ☐

Employment Information

Following is for: Patient ☐ Insurance Subscriber ☐ Employer Name:______________________________

Occupation:________________ Address____
Street City State Zip code

Insurance Information

Primary

Name of Insured:____ Is the Insured a patient? ☐YES ☐NO

Insured Birth Date________________ ID #__________________________ Group #________________

Insured Address____
Street City State Zip code

Insured Employer______________________ Address____
Street city state zip code

Insurance Plan Name and Address____

Secondary

Name of Insured:____ Is the Insured a patient? ☐YES ☐NO

Insured Birth Date________________ ID #__________________________ Group #________________

Insured Address____
Street City State Zip code

Insured Employer______________________ Address____
Street city state zip code

Insurance Plan Name and Address____

Disclosure of Medical and Financial Information

Please list anyone whom you allow our office to discuss your account with. This includes financial and/or medical information.

Name________________________________ Relationship__________________________________

Name________________________________ Relationship__________________________________

Patient Signatrue____ Date_______________________________________

Consent for Service

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services unless other arrangements are made. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office can not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I authorize Dr. Eric J. Aubert and/or his staff to release information regarding my dental treatment to referring specialist, diagnostic testing, prosthodontic dental treatment planning (ie) dental laboratory, insurance companies and/or outside agencies for the collection of payment.

In consideration of the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

____

Signature of patient, parent or guardian   Date   Relationship to Patient

Appointment Confirmation Policy

As of January 30th, 2017 there has been a change in our policy. Our office now requires that the patient confirms scheduled appointment **one** day prior to appointment. If the patient does not confirm their scheduled appointment, it is at our offices discretion to cancel unconfirmed appointment. This is a office that accepts emergencies, and it is imperative that patients confirm their schedule appointments to avoid long wait times. If the patient does not show up to a confirmed, scheduled appointment or does not call to cancel a confirmed appointment before scheduled time, without a valid excuse, our office charges a $39 dollar missed appointment fee. To avoid losing your scheduled appointment please give all valid forms of communication. Our office will Call, text, and send out emails, in order to give patients every opportunity to confirm.

I have read the above conditions of the appointment policy and agree to their content.

____

Signature of patient, parent or guardian   Date   Relationship to Patient

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly **confidential**. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and client service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations.
- If we are required by law to treat you; or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

These forms are provided as a service to subscribers to HIPAAps.com, LLC, and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your locale.

Patient Acknowledgement of Receipt

of the

Notice of Privacy Practices

Forest Park Dental
4527 Forest Park Blvd.
St. Louis, MO 63108

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (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

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains 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 at the address above 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 by such restrictions.

I authorize Forest Park Dental to discuss my care and/or billing with the following person(s):

____

Patient Name: ____________________

Signature: ____________________

Relationship to Patient: ____________________

Date: ____________

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