THE COLONY DENTIST
Comprehensive, Cosmetic, family,
Restorative & Implant Dentistry

OFFICIAL FINANCIAL POLICY

In an effort to maintain treatment fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office. Please feel free to discuss our fees with us at anytime. Before any dental treatment has begun, the patient and/or responsible party will receive a consultation regarding treatment plan and cost.

We require payment in full for the portion, not covered by dental insurance, of dental services to be rendered. For services equaling over $500.00, 50% of that cost will be required as a deposit at the time of booking the appointment. Please note that this deposit is non-refundable should the appointment be cancelled/rescheduled without two business days notice. At the conclusion of your appointment you will receive a statement outlining the services that were performed. By signing below the patient there is an understood "Assignment of Benefits" to The Colony Dentist. In some instances, the assignment of benefits is sometimes mistakenly overlooked by insurance companies and mailed to patients; and in that scenario the patient is responsible for signing the check over to The Colony Dentist, and the balance will be the patient's responsibility.

As a courtesy to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and your insurance company. We make every effort to give you an accurate estimate of what your portion of our fees will be, based on the information provided to us. However, we have no way to guarantee the actual terms of your policy. Any dispute coverage or the amount of reimbursement is between you and your insurance carrier. **By agreeing to this policy you agree to all such conditions.**

At The Colony Dentist, we schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, we require a **24-hour confirmation** on all appointments. **Please be advised you will be charged for cancellations and/or rescheduled appointments with less than 24 hours' notice** at the rate of $50.00 for examination/hygiene appointments and $75.00 for dental procedure appointments. Also note the payment for services that are provided by patients for The Colony Dentist will be applied to patient balances. Should the patient change their mind for whatever reason during treatment, the patient will still be responsible for full payment.

We appreciate your confidence in choosing our practice. Please do not hesitate to inquire with a staff member should you have any questions regarding this policy.

☐ **I have read, understood and agree to the Office Financial Policy stated above.**

Last Name: _____ First Name: _____ Birthdate: _____

Signature: _____

TIME 10:41 AM

DATE 8/19/2022

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

Referred By _____

Previous Dentist _____

Emergency Name, # _____

Physician & #: _____

Permission for Exam: _____

Permission for Xray: _____

Permission to Photo: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Time 2:15 PM

DAVID HUBBELL DDS

Date 8/2/2022

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

DAVID HUBBELL DDS
3805 MAIN STREET #114
THE COLONY, TX 75056-2836

General Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to the organization listed below for any equipment or services provided to me by those organizations. I authorize the release of any dental records or photocopies of information to my insurance company in order to determine the benefits payable for services rendered by this provider.

I understand that I am financially responsible to the organization listed below for any charges not covered by my dental benefits. It is my responsibility to notify the organization of any changes in my dental coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim or predetermination. I am responsible for the entire bill or balance of the bill if the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Organization/Provider: The Colony Dentist

Patient/Guardian Signature: _____ **Date:** _____

Financial Policy for Posterior Dental Work

We only place natural tooth colored fillings and crowns. Most of our patients prefer composite, natural-looking tooth colored fillings, and natural tooth colored crowns due to their aesthetic value.

We will submit the proper code for the work performed within *the fee guidelines allowed according to your PPO plan*; however, we cannot be responsible for the insurance company changing the codes to the least expensive service to save money. Please keep in mind that any estimate we provide you is only an insurance estimate according to the fee guidelines and that you are responsible for all fees in their entirety.

I understand that I will be billed for any difference in fees due to my insurance company changing the codes to less valuable service. I am willing to pay these fees if they should occur.

Patient/Guardian Signature: _____ **Date:** _____

Release of Information to Someone OTHER THAN MYSELF

I authorize The Colony Dentist to release dental, appointment, and/or financial information over the telephone and/or to release copies of my dental records to the following person.

Their Name: _____ **Relationship:** _____

Patient/Guardian Signature: _____ **Date:** _____

Patient Name _____