THOMAS H. HEFLIN, D. D. S., P. A.

PATIENT INFORMATION & AGREEMENT

8000 CARMEL NE, ALBUQUERQUE, NM 87122

PATIENT INFORMATION

Patient Name: _____ Date: _____

Social Security # _____ Date of Birth_____ Home Phone # _____

Cell Phone #_____ Business Phone: _____ Email_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (If different from above): _____

Marital Status: _____ Spouse's Name: _____

The date of patient's last: Cleaning _____ Exam _____ X-rays _____

Who can we thank for referring you?_____

Person Responsible for Payment (if not patient): _____ Relationship_____

Responsible Party Address: _____ City _____ Zip _____

Responsible Party Social Security #:_____ Date of Birth:_____

Employer Name:_____

Dental Insurance? _____ yes _____ no Insurance Company Name: _____

In Case of Emergency Notify:_____ Phone Number:_____

Patient Primary Physician Name:_____ Phone Number: _____

Date of Last Physical:_____

TERMS AND CONDITIONS

Payment is due at time of service. Patient and/or responsible party are ultimately responsible for payment of your account, having insurance is not a guarantee of benefits. Our office will accept assignment of your insurance benefits and file the claims as a courtesy. We will ESTIMATE your co-payment with the information given to us by your insurance company and collect that at the time of treatment. Patient and / or responsible party shall be responsible for costs incurred in enforcing the terms of this agreement including costs of collections and attorney fees. This agreement shall be enforced in accordance with the laws of the State of New Mexico.

Please be aware that there is a fee for no shows/cancellations without a 24 hour notice.
I agree that the information given is correct. I have read and I understand the above statements regarding office policy.

Responsible Party Signature_____ Date:_____

HEALTH QUESTIONNAIRE

CIRCLE

1. Has there been a change in your general health in the past year? . . . . . YES ☐ NO ☐
2. Have you been a patient in a hospital during the past two years? . . . . . YES ☐ NO ☐
   If yes, why _____
3. Have you been under the care of a physician? . . . . . YES ☐ NO ☐
   If yes, why _____
4. The name of the physician is _____
5. Have you taken drugs or medications in the past two years? .. . . . . YES ☐ NO ☐
6. If so, what, how much, and how often? _____
   _____
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by any drugs or medicine? . . . . . YES ☐ NO ☐

   ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Novacaine or other local anesthetic
8. Have you ever had any excessive bleeding requiring special treatment? . . . . . YES ☐ NO ☐
9. Circle any of the following which you have or have had:

☐ Heart Failure	☐ Anemia	☐ Artificial Joint	☐ Yellow Jaundice
☐ Heart Disease or	☐ Stroke	☐ X-ray or Cobalt	☐ Blood Transfusion
Attack	☐ Kidney Trouble	Treatment	☐ Drug Addiction
☐ Angina Pectoris	☐ Ulcers	☐ Chemotherapy	☐ Hemophilia
☐ High Blood Pressure	☐ Emphysema	(Cancer, Leukemia)	☐ Venereal Disease
☐ Low Blood Pressure	☐ Cough	☐ Arthritis	(Syphilis, Gonorrhea)
☐ Mitral Valve Prolapse	☐ Breathing Difficulties	☐ Rheumatism	☐ Cold Sores
☐ Heart Murmur	☐ Tuberculosis (TB)	☐ Cortisone Medicine	☐ Genital Herpes
☐ Rheumatic Fever	☐ Asthma	☐ Glaucoma	☐ Epilepsy or Seizures
☐ Congenital Heart	☐ Chronic Bronchitis	☐ Pain in Jaw Joints	☐ Fainting or Dizzy Spells
Lesions	☐ Hay Fever	☐ Porphyria	☐ Nervousness
☐ Scarlet Fever	☐ Sinus Trouble	☐ AIDS	☐ Psychiatric Treatment
☐ Artificial Heart Valve	☐ Allergies or Hives	☐ Hepatitis A (infectious)	☐ Sickle Cell Disease
☐ Heart Pacemaker	☐ Diabetes	☐ Hepatitis B (serum)	☐ Bruise Easily
☐ Heart Surgery	☐ Thyroid Disease	☐ Liver Disease	

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? . . . . . YES ☐ NO ☐
11. Do your ankles swell during the day? . . . . . YES ☐ NO ☐
12. Do you use more than two pillows to sleep? . . . . . YES ☐ NO ☐
13. Have you lost or gained more than ten pounds in the past year? . . . . . YES ☐ NO ☐
14. Do you ever wake up from sleep short of breath? . . . . . YES ☐ NO ☐
15. Are you on a special diet? . . . . . YES ☐ NO ☐
16. Has your medical doctor ever said you have a cancer or tumor? . . . . . YES ☐ NO ☐
17. Have you ever had surgery or x-ray treatment for a tumor? . . . . . YES ☐ NO ☐
18. Do you have any disease, condition, or problem not listed? . . . . . YES ☐ NO ☐

    _____
    _____
    _____
19. WOMEN: Are you pregnant now? . . . . . YES ☐ NO ☐
    Do you anticipate becoming pregnant? . . . . . YES ☐ NO ☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform you at the next appointment.

Date_____ Signature_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us to obtain acknowledgement
- ○ Other (Please Specify)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT: Name _____

Address: see New Patient Registration Form Patient Number: see New Patient Registration From

Persons Involved in Care:

List individuals who you would like involved in your dental care. By writing their names on this form, you consent to the release of your dental information to them. (For example, if you want us to be able to discuss dental information with your husband/wife, you must list their names below. This includes discussing fillings, crowns, insurance payments with them.) In addition, the account holder (not necessarily the insurance holder) may receive basic dental treatment information on mailed billing statements (example… John had cleaning on 1/1/07, Mary had filling on 1/1/07).

_____ _____

_____ _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

If you decide not to sign this consent, we may decline to treat you.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time. **Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you if you revoke this Consent.

CONSENT

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative / guardian on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date:_____

Relationship to Patient_____

Heflin Family Dentistry
8000 Carmel Ave NE
Albuquerque, NM 87122

Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) Cash, Check, Visa / MasterCard / Discover / American Express

2) Flexible payment plans of up to 12 months upon approval with Care Credit. Approval must be received prior to treatment date.

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes the final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore all charges are your responsibility.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a finance charge of 1.5% after 60 days. I am responsible for all collection costs incurred by the dental office. A fee of $35.00 will be assessed for all returned checks.

Broken Appointment Policy: I am aware that Heflin Family Dentistry requires an advance notice of 24 hours to change or reschedule an appointment, with exceptions to individual circumstances. I understand that I will be charged $50.00 per hour for any missed or broken appointments.

Signature of Patient and/or Legal Guardian

_____

Date: _____

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