Victus Dental

Patient Demographics Information

*=required

First Name *

Last Name *

Preferred Name

Date of Birth *

Address *

City *

State/Province *

Zip Code/Postal Code *

Gender *

Next

Victus Dental

Contact Information *=required

Cell Phone *

Home Phone

Work Phone

Ext.

Email Address *

Preferred Contact Method

Emergency Contact First Name

Emergency Contact Last Name

Relation to Patient

Emergency Contact Phone

How did you find us?

Next

Victus Dental

Medical History

*=required

Are you taking any medications, pills, or drugs?

- ○ Yes
- ○ No

If yes, please explain:

Do you have any drug or medication allergies?

- ○ Yes
- ○ No

If yes, please explain:

General Allergies

- ○ Yes
- ○ No

If yes, please explain:

Do you use tobacco?

- ○ Yes
- ○ No

Do you need to pre-medicate?

- ○ Yes
- ○ No

If yes, please explain:

Are you...

- ☐ Pregnant or trying to get pregnant?
- ☐ Taking oral contraceptives?
- ☐ Nursing?
- ☐ N/A

Do you have, or have you had, any abnormalities with the following?

- [ ] Mouth
- [ ] General Health
- [ ] Head, neck, face, scalp
- [ ] Nose, sinuses, throat, ears
- [ ] Respiratory/Lungs and chest/Breathing problems
- [ ] Cardiac / Heart / Hypertension
- [ ] Digestive System
- [ ] Neurological System
- [ ] Developmental Delays
- [ ] Endocrine system / Diabetes
- [ ] Musculoskeletal system / artificial joints / osteoporosis
- [ ] Skin / lymph nodes
- [ ] Psychiatric
- [ ] None

If you marked yes to any, please explain:

Do you have any current diseases or illnesses?

- ○ Yes
- ○ No

If yes, please explain:

Have you had any past surgeries?

- ○ Yes
- ○ No

If yes, please explain:

Are there any other significant health/illness concerns?

- ○ Yes
- ○ No

If yes, please explain:

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:

Victus Dental

Relationship to Patient *=required

Relationship:

- [ ] Patient (Above 18 yrs)
- [ ] Parent/Guardian

IF you are the Parent / Guardian, please continue below:

Relationship to patient

Date of Birth

Address

Phone

Victus Dental

HIPAA Authorization (Part 2)

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment, or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. *Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*
HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Signature

Victus Dental

Financial and Cancellation Agreement

Financial Agreement

ALL PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN AT EACH APPOINTMENT.

- We are committed to providing you with the best dental care possible, and we are willing to discuss our professional fees with you at any time.
- All patients must complete our “Patient Paperwork” before seeing our dentist and all information must be completed.
- Our office requires a form of government issued picture ID to be kept on file for all legal guardians and all patients 18 years and older.
- Payment is due when services are rendered. We accept checks, cash, Visa, MasterCard, Discover, and American Express.
- Financing is available through Care Credit. Please feel free to inquire at the front desk.

DENTAL INSURANCE

If you have dental insurance, we are willing to assist you in receiving your maximum allowable benefits. We will gladly discuss your treatment plan and any questions relating to your insurance. You must realize that:

1. Your insurance contract is between you, your employer, and the insurance company. We are not a party to that contract. We will inform you if we are a preferred provider for your insurance.
2. Usual and customary rate (UCR) is an insurance term and not a dental term. Our fees are generally considered to fall within the ucr of most insurance. Victus Dental and the dentists are not bound by these fees dictated by any particular insurance company.
3. Not all services are a covered benefit in all contracts. This difference will be described by the insurance in the explanation of benefits (EOB).
4. Predeterminations are never a guarantee of payment from your insurance.
5. Insurance benefits are only as estimate and based on information given to our office by your insurance company.
6. Insurance balances are ultimately the patient’s obligation. We will file most primary insurances at no cost to you as a courtesy. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

We must emphasize that as a dental health care provider, our relationship is with our patient and not the insurance company. Filing your insurance is a courtesy that we extend to our patients and all fees are the patient’s responsibility from the date the service is rendered.

- Returned checks will be subjected to a 25.00 Charge.
- Balances older than 90 days will be referred to a collection agency. The patient will be responsible for any fees associated with this action.
- Please allow 24 hours notice for rescheduling appointments to avoid a broken appointment fee or dismissal from the practice.

Thank you for understanding the financial policy. Please let us know if you have any questions or concerns.

Cancellation Agreement

Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved or dismissal from the practice, as this time could be given to another patient in need.

We require all appointments to be confirmed. Unconfirmed appointments are subject to being marked as a No-Call-No-Show and could lead to dismissal from the practice.

I understand that and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

Signature

Next

Victus Dental

HIPAA *=required

HIPPA OMNIBUS RULE: PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELAEASE FORM

☐ You may refuse to sign this acknowledgment and authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

Patient or Legal Guardian Name

Signature:

I acknowledge and agree that by entering my name in the signature and submitting this form digitally, this constitutes an electronic signature as defined by the Electronic Signatures in Global and National Commerce Act and that this document is non-refutable, valid and legally binding.

Was the previous signed by patient or guardian?

☐ Patient (18 year and above)

☐ Legal Guardian

If Legal Guardian, list full name and relationship:

Please list any other parties first and last name who can have access to your health information and consent to treatment. (This includes any parties bringing a minor to appointments such as grandparents, step-parents, siblings, etc.)

Party #1:

Party #2:

Party #3:

Victus Dental

Pediatric Dental Consent Form

PEDIATRIC DENTAL CONSENT FORM

As health professionals, it is necessary that we obtain your consent for oral treatment on your child. Please read this carefully and ask any questions that may not be clear or that you may not understand.

I authorize Victus Dental to treat my child for the following dental or oral surgery procedures; including the use of oral anesthesia, nitrous oxide, and sedatives or radiographs that may be necessary.

In general terms these procedures include:

A. Dental cleaning, fluoride application and radiographs as necessary
B. Application of sealants to dental fissures
C. Restoration of broken teeth or fillings
D. Treatment of infected teeth or gums
E. Extractions of one or more teeth
F. Use of analgesia- Nitrous Oxide- due to behavior

My child's treatment, alternative methods of treatment, as well as advantages and disadvantages of each have been explained to me. I have been advised that although the best results are expected, there is no way within reason of anticipating complications; therefore it is not possible to guarantee the results or cure the treatment.

Although the occurrence is extremely remote, it is known that some risks are associated with dental procedures. We are required to mention the following: numbness, infection, damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars.

I understand that certain complications may be fatal or require future medical intervention.

For patients 18 years and older, please put N/A in the signature box.

Signature