Patient Information (CONFIDENTIAL)

How did you hear about us? ____________________

Star City Dental can now confirm appointments by email or text.
Please check your preference:

☐ Email ☐ Text ☐ Home Phone ☐ Cell Phone

Are you interested in our in-house payment program through Cherry Finance or Care Credit?

☐ Yes ☐ No

☐ Check this box if you agree to receive commercial electronic messages from Star City Dental. These messages may be related to your appointment, your health care, or the products and services we provide to our patients.

Name ____________ Birthdate ________ Home Phone ________ ☐ M ☐ F

Address ____________ City ________ State ______ Zip ______

Email ____________ SS# ________ Cell Phone ________

If Full Time Student, Name of School/College ____________ City ________ State ______

Patient or Parent/Guardian's Employer ____________ Work Phone ________

Business Address ____________ City ________ State ______ Zip ______

Spouse or Parent/Guardian's Name ____________ Employer ________ Work Phone ________

Emergency Contact ____________ Phone ________

Responsible Party (IF SAME AS PATIENT, SKIP TO THE NEXT SECTION)

Name of Person Responsible for this Account ____________ Relationship to Patient ________

Address ____________ Home Phone ________

Birthdate ________ Email ____________ Cell Phone ________

Employer ____________ Work Phone ________ SS# ________

Patient Dental History

Name of Previous Dentist and Location ____________ Date of Last Exam ________

1. Have you ever been diagnosed with periodontal disease? ____________
2. Have you ever been told that you snore? ____________
3. Do you like your smile? ________ How would you rate your smile on a scale from 1-10? ________
4. What changes would you make to improve your smile? ____________

Insurance Information (IF CARD(S) IS AVAILABLE, SKIP TO THE NEXT SECTION)

PRIMARY INSURANCE

Name of Insured ____________

Relationship to Patient ____________

Birthdate ____________

SS#/ID# ____________

Name of Employer ____________

Insurance Company ____________

Group # ____________

Policy ID # ____________

SECONDARY INSURANCE

Name of Insured ____________

Relationship to Patient ____________

Birthdate ____________

SS#/ID# ____________

Name of Employer ____________

Insurance Company ____________

Group # ____________

Policy ID # ____________

Over Please...

NOTICE OF PRIVACY PRACTICES

HIPPA PRIVACY

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and provider certifications.

I acknowledge that I have read and may request a copy of Star City Dental's *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that Star City Dental restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations. I also understand Star City Dental is not required to agree to my requested restrictions, but if in agreement, Star City Dental is bound to abide by such restrictions.

Signature: ______________________________ Date: ______________

I give my permission to discuss my dental treatment (including, but not limited to: Treatment, Scheduling, Billing, Insurance) with the following groups or individuals: ______________________________

____

Signature: ______________________________ Date: ______________

4525 S 86TH
LINCOLN, NE 68526
(402) 489-7806

HEALTH HISTORY FORM

Patient Name: ______________________________

Last | First | MI | Preferred Name

Patient Medical History

Please list your Physician's name, phone number and date of your last exam.

____

____

Have you been hospitalized for any surgical procedure or serious illness within the last 5 years? ◯ Yes ◯ No

If yes, please explain:

____

____

Are you taking any medication(s) including non-prescription medicine? ◯ Yes ◯ No

If yes, what medication(s) are you taking?

____

____

Do you require or has your physician recommended a pre-med antibiotic prior to dental treatment? ◯ Yes ◯ No

If yes, for what reason?:

____

____

Do you use tobacco/ e-cigarettes? ______________________________

Do you use controlled substances? ______________________________

Are you taking any blood thinners? ◯ Yes ◯ No

If yes, most recent INR: ______________________________

Are you taking any bone strengthening medications such as Prolia, Frosamax, Boniva, Fosamax, Boniva, Reclast? ◯ Yes ◯ No

Do you have or have you had Cancer? ◯ Yes ◯ No

If yes, type of cancer and treatment:

____

____

Do you have Diabetes? ◯ Yes ◯ No

If yes, Type and most recent A1C: ______________________

Have you had a Heart Attack or Stroke? ◯ Yes ◯ No

If yes, Date of Heart Attack or Stroke: ______________________

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

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Azithro
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Ibuprofen
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Allergy - Any Metals
- ☐ Allergy - Local Anes
- ☐ Allergy - Acrylics
- ☐ Allergy - Food Alerg
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Heart Val
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cholesterol
- ☐ Cognitive Impairment
- ☐ Cong. Heart Defect
- ☐ C-PAP
- ☐ Dental Anxiety
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Hearing Impairment
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes/Cold Sores
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Infect. Endocarditis
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Organ Transplant
- ☐ Osteoporosis Meds
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Psychiatric Cond
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors

Women Only:

Are you pregnant or think you may be pregnant? ◯ Yes ◯ No

If yes, due date: ______________________

Are you nursing? ◯ Yes ◯ No

Are you taking oral contraceptives? ◯ Yes ◯ No

Notes:

____

____

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____

Signature Date

Financial Policy

Our Mission at Star City Dental is to save patients pain, time, and money. Before any work is performed, we will discuss treatment and financial options so there are no surprises.

Payment for your estimated portion of the fees is required on the day services are rendered. We accept cash, personal checks, money orders, Mastercard, Visa, Discover, American Express, Cherry, and Care Credit. If a personal check is returned for non-sufficient funds (NSF), you may be charged a third party collection fee. You will also be required to pay with either cash or credit card for any future visits.

Cherry and Care Credit are available in our office, and provide extended payment plans with prior credit approval.

Emergency patients without insurance, who are new to our office, should expect to pay their portion, in full, upon check-in.

Our Dental Savings Plan, an alternative to traditional dental insurance, is designed to save you pain, time, and money. It's a great way to get the care you need with the savings you want. Ask our team for more information today.

Dental insurance is a contract between the group/plan and the patient. The extent of coverage varies greatly between plans and sometimes even within a single plan. We only recommend treatment according to our standard of care, regardless of insurance coverage. **ANY BALANCE NOT COVERED BY YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY.** Please note that the portion you pay on the date of your service is only an estimate, and may change depending on the insurance coverage. We will submit your insurance claim as a courtesy to you. If your insurance pays differently than our estimate, we will either refund you or the remainder will be due within 15 days of the first statement date.

In the case that you have an unpaid remaining balance after all insurance is paid, we will attempt to reach you to collect. In the event that we are unsuccessful, we may place your account with a collection agency. Upon placement, we will add a minimum fee of 24% to the total balance to cover the cost of collections fees, litigation costs, and any other additional fees that may occur.

Appointments are reserved exclusively for you. Some appointments may require a non-refundable deposit to hold your reservation. Your deposit will apply to your estimated patient portion, if completed as scheduled. The clinic requires a notice of at least one (1) full business day if the patient is unable to keep the reserved appointment time. We will attempt to contact you prior to your appointment to confirm your reservation. If an appointment is not confirmed within one business day of the appointment, the appointment may be canceled or rescheduled. **You may be charged for missed appointments or cancellations with less than 1 full business day's notice. If a patient "no-shows" or an appointment is "short-notice canceled" for three appointments, we will move you to a same-day-only scheduling list.** As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening should arise.

In the case of separated or divorced parents of minors, who are responsible for a portion of the cost of a child(ren)'s treatment: The parent who brings the child to the appointment is responsible for paying the patient portion on the day of service.

☐ I have read and understand this financial and cancelation policy.

Patient　　　　　　　　　　　　　　Date

Patient/Guardian Signature　　　　　　　　　　　　　　Date