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, Sunbit, or Care Credit?

☐ Yes ☐ No

STAR CITY DENTAL

☐ 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...

STAR CITY DENTAL

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

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

STAR CITY DENTAL

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 _____

NOTICE OF PRIVACY PRACTICES

HIPAA 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: _____

YOUR PRIVACY MATTERS

STAR CITY DENTAL

Our dental team is committed to protecting your personal health information. This sheet provides a quick overview of how your information may be used and your rights.

How Your Information May Be Used

- Treatment – To provide and coordinate your dental care
- Payment – To process insurance claims or payments
- Operations – To improve services, train staff, and manage our practice

When Information May Be Shared

Your information may be shared when required by law for public health, safety, or legal reasons.

Special Privacy Protections

Some health information, including certain substance use disorder treatment records, receives additional federal protections. Our practice follows these laws to ensure your privacy is maintained.

Your Rights

- Request copies of your dental records
- Ask us to correct information in your record
- Request confidential communication methods
- Ask for restrictions on certain uses of your information
- Receive a full copy of our Notice of Privacy Practices

Questions?

If you have questions regarding privacy practices, please contact:

Star City Dental
Privacy Officer
6709 S Minnesota Ave
Sioux Falls, SD 57108
605-213-1007
hr@neighborhooddentalcare.com

To view the full Notice of Privacy Practices, please visit the privacy page on our website.