## Welcome to Valley Dental Associates!

Dr. Robert J. Winebrenner, DDS, PA

Please complete all parts of this registration for our records. This information is strictly kept confidential.

## Patient Registration

Reason for Today's Visit: _____

Name: _____ Sex: ____ M ____F

Home Phone: _____ Work Phone:_____Cell Phone: _____

Email Address: _____

Home Address: _____City: _____ Zip Code: _____

Patient Social Security #: _____ Date of Birth:_____

Marital Status: Married Divorced Legally-Separated Single

Full Time Student: Yes No Name of School: _____

Whom may we contact in the case of an emergency?_____ Phone:_____

**Whom may we thank for referring you to us?** _____

Who is responsible for this bill? _____

Employer_____

**Dental Insurance Information**

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Dental Insurance Carrier Name, Address, Phone #: _____

Is the medical and dental carrier the same? Yes No

Insured's Employer Name and Address:

_____

Employer Phone#: _____

**Secondary Dental Insurance Information**

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Dental Insurance Carrier Name, Address, Phone #: _____

**Medical Insurance**

If information is the same as the information above indicate with "Same" and indicate which policyholder is applicable in the appropriate data fields.

**Medical Insurance Information or a third carrier**

Name of Insured: _____

Relationship to Patient: _____

Policyholder Date of Birth: _____

Policyholder Social Security #: _____

Insurance Carrier Name, Address, Phone #:_____

Eligibility date indicated on card as: _____

Is this plan HMO, PPO or EPO Yes NO (circle the correct response)

If this is for EHB; who administers the plan: _____

**Accident or Injury Information**

If this claim is accident related: Yes No

If yes, please provide details of the accident:

Date: _____Location:_____

Details of accident or injury:

_____

Did you consult another medical physician regarding any other injuries resulting from this accident?

Name of physician: _____

Date first seen by other physician: _____

Could this injury be covered under Worker's Compensation? Yes No

**There are dental conditions that may have a medical complication or etiology. To best assist our patients we find having all information a valuable resource in determining the patient needs and insurance coverage.**

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1. When was your last Dental Examination and Cleaning? _____Previous Dentist_____

2. Have you been a patient in the hospital during the past two (2) years?.....Y/N

If yes, please explain_____

3 Have you been under the care of a medical doctor during the past two (2) years?.....Y/N

If yes, please explain_____

Physician's Name_____ Phone Number ____-____- _____

4. Have you taken any medicine or drugs in the last two (2) years?.....Y/N

5. Are you now taking any prescribed or non-prescription medication, drugs, or pills?.....Y/N

If yes, please list_____

_____

6. Are you allergic or have you reacted adversely to any of the following medications?

(please circle YES or NO)

| | | | |
|---|---|---|---|
| Aspirin Y/N | Nitrous Oxide Y/N | Valium Y/N | Local Anesthetic Y/N |
| Darvon Y/N | Erythromycin Y/N | Scopolamine Y/N | Novocain Y/N |
| Codeine Y/N | Tetracycline Y/N | Penicillin Y/N | Sleeping Pills Y/N |
| Demerol Y/N | Percodan Y/N | Antibiotics Y/N | Xylocaine Y/N |
| Latex Y/N | | | |

7. Are you aware of being allergic to any other medications, food, or substances?.....Y/N

If yes, please list_____

8. Have you ever had or do you have at present:

| | | |
|---|---|---|
| Abnormal Bleeding Y/N | Drug Abuse Y/N | Pace Maker Y/N |
| Alcohol Abuse Y/N | Emphysema Y/N | Pain in Jaw Joint Y/N |
| Allergies Y/N | Epilepsy Y/N | Psychiatric Problems Y/N |
| Anemia Y/N | Fainting Spells Y/N | Radiation Therapy Y/N |
| Artificial Heart Valve Y/N | Fever Blisters Y/N | Seizure Y/N |
| Artificial Joint or Bone Y/N | Frequent Headaches Y/N | Shingles Y/N |
| Asthma Y/N | Glaucoma Y/N | Sinus Problems Y/N |
| Blood Transfusion Y/N | HIV/AIDS Y/N | Sleep Apnea Y/N |
| Bruise Easily Y/N | Heart Attack Y/N | Snoring Y/N |
| Cancer Chemotherapy Y/N | Heart Disease Y/N | Stroke Y/N |

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| | | |
|---|---|---|
| Cold Sores Y/N | Heart Surgery Y/N | Thyroid Problems Y/N |
| Congenital Heart Defect Y/N | Hemophilia Y/N | Tuberculosis Y/N |
| Cortisone Medicine Y/N | Hepatitis A, B, or C Y/N | Ulcers Y/N |
| Cosmetic Surgery Y/N | High Blood Pressure Y/N | Venereal Disease Y/N |
| Diabetes Y/N | Liver Disease Y/N | Yellow Jaundice Y/N |
| Difficulty Breathing Y/N | Low Blood Pressure Y/N | |
| Difficulty Sleeping Y/N | Narcolepsy Y/N | |

9. When you walk up stairs, do you ever have to stop because of pain in your chest or shortness of breath?.....Y/N

10. Do your ankles swell during the day?.....Y/N

11. Do you use more than two (2) pillows to sleep?.....Y/N

12. Have you lost/gained more than 10 pounds in the last year?.....Y/N

13. Do you ever wake up from sleep short of breath?.....Y/N

14. Are you on a special diet?.....Y/N

15. Has your medical doctor ever said you have cancer or a tumor?.....Y/N

16. Do you have any disease, conditions or problems not listed?.....Y/N

If yes, please explain_____

_____

17. Do you smoke?.....Y/N

18. Do you participate in any activity that would increase the possibility of HIV infection?.....Y/N

19. Have you ever had an HIV blood test?.....Y/N

Date_____ Result_____

20. Have you ever experienced a sensitivity to latex?..... Y/N

21. Have you taken or are you taking Biphosphonates (Aridia, Fosamax, Actonel, etc.).....Y/N

22. Have you ever taken Fen-Phen or Redux?.....Y/N

23. Is there any other medical information you would like us to know?.....Y/N

If yes, please explain_____

_____

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## CONSENT

The undersigned hereby authorizes Doctor, after consultation with patient (or parent, if minor) to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriated by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapies that may be indicated and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also under the use of anesthetic agents carry a certain risk.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

I certify the above information is true and correction:

_____ _____

**Patient/Guardian (If under 18) Signature** **Patient's Name**

_____ _____

**Doctor Signature** **Date**

**FOR WOMEN ONLY**

Are you pregnant?.....Y/N

If yes, what week?_____Are you taking birth control pills?.....Y/N

If yes, what is the name of the prescription?_____

## Valley Dental Associates

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I, _____, have read and received a copy of this office's Notice of Privacy practices.**

_____
**Please Print Name**

_____
**Signature**

_____
**Date**

**We may use or disclose your health information to a physician or other health care operations. We may use or disclose your health information to a physician or healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment to services we provide for you (insurance companies). We may use and disclose your health information in connection with our healthcare operations. These include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professions, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. You may also give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. However, your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We must disclose your health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We will NOT use your health information for marketing communications without your written authorization. We may use or disclose your health information when we are required to do so by law. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose to military authorities the health information of Armed Forces Personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances. We may use or disclose your health information to provide you with appointment reminders (phone calls, e-mails, post cards). You have the right to get copies of your health information, with limited exceptions. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in the case of an emergency. IF YOU RECEIVE THIS NOTICE ON OUR WEBSITE OR BY ELECTRONIC FORM, YOU ARE ENTITLED TO RECEIVE THIS NOTICE IN WRITTEN FORM, UPON REQUEST.**

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# Smile Self-Evaluation

**Name**_____
Today's Date_____

**Please complete this evaluation so we know how to help you achieve the smile that will make you happy.**

1. Are you 100% happy with the appearance of your teeth and your smile? YES NO
   If no, what would you like to change, if possible?
____ the color of my teeth
____ the shape of my teeth
____ spaces between my teeth
____ uneven teeth
____ chipped teeth
____ amount of gum tissue that shows when I smile
____ crooked or overlapping teeth that show when I smile
____ visibly missing teeth
____ visible metal restorations
____ discolored restorations
____ old crowns, bridges, or dentures
____ other – please explain in detail_____
_____
_____
_____

2. Are any of your teeth loose or causing you discomfort? YES NO
   If yes, please explain in detail_____
_____
_____
_____

3. Do you have any questions about dentistry or your oral health that have never been adequately answered? YES NO
   If yes, please explain in detail_____
_____
_____
_____
_____

4. Is there anything you would like the Doctor or Hygienist to discuss with you today? YES NO
   If yes, please explain in detail_____
_____
_____
_____

5. Would you like one of our Business Assistants to discuss dental financings programs available through Care Credit? YES NO

Valley Dental Associates
*13424* Pennsylvania Avenue, Suite *301*
Hagerstown, Maryland *21740*
*301-733-3414*

**Authorization for Release of Protected Health Information to a Specified Spokesperson**
*As stated in the Valley Dental Associate's (VDA) Notice of Privacy Practices, "We may release health information about you to a family member, other relative, or any other person identified by you who is involved in your care with your permission."*

**By signing this authorization, I allow VDA to tell the spokesperson(s) named below to the following information:**
My x-rays, laboratory, test findings, diagnosis, prognosis, and treatment plan either in person or by telephone.

**By signing this authorization, I understand the following.**

- This applies to services being rendered to me by Valley Dental Associates.
- This authorization is voluntary.
- Once this information is released to the spokesperson(s), the released information may no longer be protected by the federal privacy regulations.
- The spokesperson(s), medical power of attorney, health care agent or other individual allowed by law will be the only person(s) who may obtain specific information about me.
- My spokesperson(s) does not have decision-making abilities unless he/she is able to do that as set forth in the law.
- I may withdraw this authorization at any time by notifying the Valley Dental Associates Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by VDA prior to receiving the written request.
- My treatment will not be affected by me choosing to sign or not to sign this document.
- I may refuse to sign this authorization

**You may receive a copy of this form once it is completed**

Print Patient's Name_____DOB_____

**Spokesperson Information:** **PRINT CLEARLY**

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

**Patient's Signature** _____Date_____

# FINANCIAL POLICY

We, the staff of Valley Dental Associates thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact our office manager at (301)733-3414.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff. We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, and in-state checks). A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

**Interest:** Interest will incur if a balance remains unpaid after 30 days.

**Insurance:** Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability

with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of- network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

**Miscellaneous Forms, Additional Information and Authorizations:**

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

**Missed Appointments:**

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $50.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

**Medical Records Fees:**

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

**Timeliness of Appointments:**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

**Signature of Insured or Authorized Representative:** _____

**Date:** _____

## Assignment of Benefits Form

Valley Dental Associates

13424 Pennsylvania Avenue Suite 301

Hagerstown, MD 21742

(301) 733-3414

Date:_____

**Patient:**_____

ID#:_____

Group#:_____

I, _____, understand that services rendered to me by Valley Dental Associates are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to Valley Dental Associates and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____(insurance company).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Valley Dental Associates within 48 hours. I agree that if I fail to send the payment to Valley Dental Associates and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

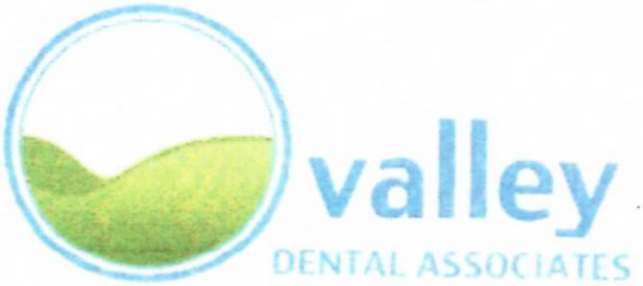
To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Valley Dental Associates to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Valley Dental Associates to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

**Dated**_____ **Witness** _____

_____ _____

**Policyholder Name** **Patient or Guardian**




Non-covered Services Acknowledgement Form

I, _____, understand that the services performed by and/or supplies prescribed by the doctors and staff of Valley Dental Associates, may not always be considered eligible for benefits by my insurance carrier. I understand that my insurance coverage has certain restrictions, as well as non-covered services and supplies.

Nearly all dental benefit plans are the result of a contract between the plan sponsor (usually an employer or a union) and the third-party payer (usually an insurance company). The amount the plan pays is determined by the agreement negotiated by the employer with the insurer. Dental coverage is determined not by the patient's dental needs, but by how much the employer contributes to the plan.

If my dependent or I choose to receive the services and/or supplies prescribed by the doctors and staff of Valley Dental Associates, and they are not covered by my insurance, I agree in advance to accept full financial responsibility for all costs associated with the non-covered services.

_____

PATIENT/ GUARDIAN SIGNATURE

_____

DATE