Buffalo Dental Implant
New Patient Form

First Name: _____ Last Name: _____

Date Of Birth: _____ Cell Phone: ( )_____ Home Phone: ( )_____

Address: _____
Number and Street City State Zip

Email Address: _____ Social Security # _____

Emergency Contact: _____ Phone: _____ Relationship: _____

We participate with (and are in network with) the following insurance companies. Qualifying plans are through employer supplied PPO plans only.

Aetna PPO
Buffalo Teacher Federation
Cigna PPO
CSEA
Delta Dental PPO and Premier
Dental Pay/Pro Benefits/Dental Shop
Univera PPO
GEHA
GHI (Emblem)
Guardian PPO
Metlife
Nova
United Concordia

At this time, we are not in network with any Medicaid/Medicare plans, even if they are offered through one of the above insurance carrier names.

Your Insurance Information

Primary Dental Insurance Name: _____

Insurance Holders Name: _____ **Relationship to you:** _____

Insurance Holders Social Security Number: _____ **Insurance Holders Date of Birth:** _____

Insurance ID Number: _____ **Group Number:** _____

Secondary Dental Insurance Name: _____

Insurance Holders Name: _____ **Relationship to you:** _____

Insurance Holders Social Security Number: _____ **Insurance Holders Date of Birth:** _____

Insurance ID Number: _____ **Group Number:** _____

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BDI/BDAC Financial Policy

Self Pay patients (patients without dental insurance or patients who have dental insurance with which we are not in network) are required to pay for our services in full at the time the services are rendered.

Insured patients (patients who have dental insurance with which we do participate as listed on page 2) are required to pay the amount of their estimated co-pay and deductible at the time of service. Insured patients are responsible for providing us with complete, accurate, and up-to-date information in order for us to successfully bill your insurance company. You are responsible to pay applicable deductibles, copayments, coinsurance, outstanding balances, and/or any portion the insurance determines that you as the the insured are responsible for at the time of service. If BDI/BDAC participates with your insurance company, your maximum bill will be for the contracted fees.
Insured patients will be responsible for any charges that their insurance company does not cover, and for any open claims, after 90 days past service.

All patients - Promise to Pay: You promise to pay all amounts owed on your account under the terms of this financial policy. The expected amount to be paid by your insurance company may be charged to your account until we receive payment from your insurance company. In the event that your insurance company is slow to pay or denies a claim, payment of your account is your responsibility. In this instance, we will provide a statement of your account to you, which will be payable at that time.

Missed Appointment Fee: We may charge between $45 - $150 to your account for a missed appointment or for an appointment cancelled without 24 hours notice.

Collection Costs: If we don't receive payment within 120 days, then your account will be referred to a collection agency and you will be charged all collection costs.

Returned Checks: A $35.00 fee will be assessed on any check returned unpaid.

BDI/BDAC is not an insurance provider and is not responsible in the event that your insurance company decides to deny payment for any services rendered.

I have read and fully understand my responsibilities and obligations as per the BDI/BDAC Financial policy.

Name Printed: _____

Name signed : _____

Date: _____

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Have you ever been hospitalized or had any surgeries? If yes, please list what it for and when :

Please check box next to any applicable conditions. Please specify the issue that you have if applicable.

- ❑ Heart Problems
- ❑ Rheumatic Fever
- ❑ Diabetes
- ❑ Valve Replacement
- ❑ Hepatitis
- ❑ Pacemaker
- ❑ Herpes
- ❑ Kidney Problems
- ❑ HIV/AIDS
- ❑ Glaucoma
- ❑ Liver Problems
- ❑ Transplant of any kind
- ❑ Lung/Breathing Problems
- ❑ Thyroid Disease
- ❑ Had a transplant Blood Transfusion
- ❑ Epilepsy/Seizures
- ❑ Alcohol/Drug Abuse:
- ❑ Cancer
- ❑ Pins/Screws anywhere
- ❑ Bleeding Disorder
- ❑ Osteoporosis
- ❑ Knee/Joint Replacement
- ❑ Stomach Problems
- ❑ Breast Implants

Do you have any health problem(s) or condition(s) that are not specifically listed ? Please list here:

Please list all medications and supplements here:

Have you ever taken Fosamax, Reclast, or any other Bisphosphonate?

Do you require antibiotics prior to dental treatment? If yes, please explain why:

Do you have any allergies including any allergies to medications? If yes, please list:

How did you hear about us?

- ❑ TV Ad
- ❑ Facebook
- ❑ Online/Google Search
- ❑ Referred by a current patient
- ❑ Referred by my current dentist
- ❑ Insurance Website
- ❑ My Employer
- ❑ Pennysaver/Newspaper
- ❑ Radio
- ❑ I walked/drove by and decided to come in
- ❑ My Previous Dentist came here _____
- ❑ Other _____

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If you were referred to us by your own current dentist, please write their name and phone number here below:

Dentist's Name: _____Phone:_____

Your Pharmacy's Name: _____Phone: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

*****By signing below, I confirm that I have been informed of my rights to 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:**

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practice*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the current address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT I have read this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Patient Signature: _____

Date: _____

Printed Name: _____