ALCAN FAMILY DENTAL

Welcome to Alcan Family Dental, Dr Brett Lopez DMD

Our goal is to create a comfortable experience each time you visit.

PATIENT INFORMATION

PATIENT NAME: _____ □ Male □ Female □ Single □ Married □ _____

Cell Phone _____ Home Phone_____

Address _____

City _____ State _____ Zip Code _____

Email _____Birthdate_____Social security#_____

Who may we thank for referring you? Friend/Family_____ Google/Website/Location

Emergency Contact Name _____ Phone Number _____

Employer _____ Work Phone _____

INSURANCE BILLING

Would you like us to bill your dental insurance? □ Yes □ No

PRIMARY Insurance Company Name _____ Phone #_____

Policy Holder Name _____ Policy Holder DOB _____

Member ID _____ OR SS#_____

SECONDARY Insurance Company Name _____Phone #_____

Policy Holder Name _____Policy Holder DOB _____

Member ID _____ OR SS#_____

ABOUT YOUR INSURANCE & FINANCIAL COMMITMENT

As a courtesy, our team will submit insurance claims on your behalf. We ask that you provide us with the most current dental insurance information and update us as often as changes occur. In addition, we ask that you review your plan and understand the details of coverage including plan limitations, frequencies, waiting periods and **yearly** maximums. Please also inform us if you have used benefits at another dental office within your plan year. We will provide insurance cost **estimates** to you. It is your responsibility to contact your insurance company if no payment has been made on your claim after 30 days from the date of service**.** We have a variety of payment options including Cash, Check, Credit Cards, Cherry, and CareCredit.

I agree to keep my account balance in good standing by closing all balances greater than 45 days past all dates of service. I understand there will be a finance charge for balances over 60 days of 10% annum and that I agree to pay all collection fees should my account not be paid in full as agreed.

_____**By signing this form, I acknowledge that I have read and agree to the above information. I understand that I am financially responsible for my account for any treatment provided, regardless of insurance payment or non-payment.**

DENTAL HISTORY

What is most important to you about the way your teeth look, feel, and function?

Last Dental visit_____ Last x-rays_____

What has stood in the way of you completing the dental treatment you may need?

□Fear □Time □Cost □Lack of urgency □None

Have you ever been told that you need to be pre-medicated before dental treatment? □ Yes □ No
Have you ever been told you have Periodontal Disease? □ Yes □ No

How can we make your visits most comfortable? _____

HEALTH HISTORY

Women: Are you Pregnant? □ Yes □ No Do you smoke or use tobacco in any form? □Yes □ No

When was your last routine medical exam? _____ Physician Name_____

Please list any medications/supplements you are taking: _____

Please list any serious medical conditions, surgeries, and/or hospitalizations that you have had:

_____

Have you had or have any of the following:

Y N	Y N	Y N	Y N
□ □ A.I.D.S / H.I.V	□ □ Diabetes: I II (circle)	□ □ Heart Failure	□ □ Mental Disability
□ □ Anxiety	□ □ Drug/Alcohol Abuse	□ □ Heart Murmur	□ □ Osteoporosis
□ □ Angina Pectoris	□ □ Emphysema/Asthma	□ □ Heart Pacemaker	□ □ Rheumatic Fever
□ □ Arthritis/Rheumatism	□ □ Epilepsy/Seizures	□ □ Heart Surgery	□ □ Shingles
□ □ Artificial Heart Valve	□ □ Fainting/Dizzy Spells	□ □ Hemophilia/Bleed Easily	□ □ Sickle Cell Disease
□ □ Artificial Joints	□ □ Fever Blisters/Cold Sores	□ □ Hepatitis A B C (circle)	□ □ Thyroid Disease
□ □ Anemia	□ □ Frequent Headaches	□ □ High Blood Pressure	□ □ Tuberculosis (TB)
□ □ Chemotherapy/Radiation	□ □ Glaucoma	□ □ Low Blood Pressure	□ □ Ulcers
□ □ Congenital Heart Defect	□ □ Hay Fever/Sinus Trouble	□ □ Kidney Failure/Dysfunction	□ □ STD
□ □ Cosmetic Surgery	□ □ Heart Disease/Attack/Stroke	□ □ Liver Disease/Jaundice	□ □ Other_____

Allergies:

Y N	Y N	
□ □ Antibiotics	□ □ Aspirin	□ None
□ □ Codeine	□ □ Latex	□ Other: _____
□ □ Metals/Jewelry	□ □ Local/Dental Anesthetic	

APPOINTMENT COMMITTMENT

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time. **If circumstances occur and it's necessary for you to change your scheduled appointment, we request a 24-hour notice. A no call/no show is not acceptable and will result in a $50.00 lost appointment fee that must be paid prior to future appointments.** Please be courteous and call us to discuss the best times for scheduling your appointments so we can complete the dentistry you need to keep your teeth healthy.
Please Initial Here _____I acknowledge that I have read and understand this.

PATIENT CONSENT

I authorize Dr Brett Lopez DMD, Alcan Family Dental to provide treatment based on his recommendations & my oral health care needs. I understand that I will be informed of any treatment needed and will have the opportunity to ask questions regarding treatment, costs, and insurance estimates, before proceeding with treatment. I agree to communicate any changes to my dental/medical condition(s) at each visit.

Patient printed name: _____**Patient Signature**: _____Date: ___/___/___

Alcan Family Dental, Brett Lopez DMD, 2819 Dawson Street Anchorage, Ak 99503 907-562-4774

About your Insurance

We understand how important insurance benefits are to you. Your Dentist will be recommending the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions.

Dental insurance is a contract between you and your insurance company. As a courtesy, when you provide your current insurance card billing information, we will assist you with filing your electronic dental insurance claim(s) they are typically paid by your insurance within 10-30 days.

Your insurance has a yearly maximum, and **anything over that and co-pay amounts are your responsibility.** Deductibles, copays, and over maximum insurance must be paid on the date of service. If dental services has been provided for you by another provider within your benefit year, those fees will count toward your maximum as well. If you have two insurance policies, not **all policies will cover remaining portions after your primary insurance has paid.**

I have read & agree to Alcan billing my insurance and understand the details.

Patient/Parent Initial Here _____ I don't have dental insurance *Patient/Parent Initial here* _____

Financial Agreement

To provide you with the highest quality dental care, we provide our patients with ***estimates of fees*** before dental treatment.

We provide payment options as: Cash, Check, Major Credit Cards, Cherry & CareCredit. A $35.00 fee will be charged for returned checks or failed electronic payments.

Estimated patient copays are due on the date of service. If your insurance does not pay the estimated amount, you as a patient, parent and/or guardian are responsible for your account balance.

You will receive a monthly statement from us advising you of any unpaid balance on your account after insurance pays your dental claim, and a 10% yearly interest may be charged for unpaid balances over 60 days.

We reserve the right to postpone non-emergency treatment on accounts with outstanding balances.

Accounts over 90 days may be referred to Cornerstone credit services after reasonable attempts to collect.

I have read and agree to pay any balance on my account from services provided to myself or my dependents.

Parent/Patient Initial Here _____

Appointment Commitment

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time. **Patients will receive reminders by text, phone or email.** If we are unable to confirm your appointment time, your time may be released to another patient on our waiting list. Repeated unconfirmed, late or no-show appointments may require same day scheduling or a deposit to reserve a future appointment. If you arrive 15+ minutes late, your appointment is subject to rescheduling.

If circumstances occur and it's necessary for you to change your scheduled appointment, we request a 24-hour notice. Less than 24 hours, or a no call/no show, will result in a $50.00 lost appointment fee that must be paid prior to future appointments.

I have read & acknowledge that I understand appointment fees will not be billed to insurance. *Parent/Patient initials* ____

HIPAA

Health Insurance Portability & Accountability Act Notice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect today and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing you treatment.
Payment: We may use and disclose your health information for billing purposes to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations such as billing your insurance, referral of records to a specialist, reviewing the competence or qualifications of healthcare professionals, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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.
Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) 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 incapacity 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.
Marketing: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: 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.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text message, emails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with a written request with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If you prefer, we will prepare a summary or an explanation of your health information.
Disclosure Accounting: 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.
Restriction: You have the right to request that we place additional restrictions on our use or 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 an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

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We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Brett Lopez DMD :907-562-4774 2819 Dawson Street, Anchorage, Ak 99503 scheduling@AlcanFamilyDental.com

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices.
The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment of services, or in the performance of the office's health care operations. This Notice of Privacy Practices also describes my rights and the responsibilities and duties of the office with respect to my protected health information. Alcan Family Dental reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective.

Signature of Patient/Parent_____Date_____

I authorize Dr Brett Lopez DMD, & Alcan Family Dental to share my information with the individual(s) listed below:

Name _____ Relationship _____

Name _____ Relationship _____