Registration and Billing

SECTION 1: Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ DOB: _____ SSN: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

SECTION 2: Benefits and Billing Information

I. Primary Insurance Company & Plan Name: _____Employer: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holders SSN: _____ Relation to patient:_____ Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

Policy Holders address: _____ City: _____ State: _____ Zip: _____

II. Secondary Insurance Company & Plan Name: _____Employer: _____

ID Number: _____ Group/Policy Number: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holders SSN: _____ Relation to patient:_____ Policy Holder's Gender (circle): Male Female

Is your Primary Insurance Policy a (circle): POS PPO EPO HMO Don't Know Other (specify): _____

Policy Holders address: _____ City: _____ State: _____ Zip: _____

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

I understand that all deductibles are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts may be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Dr. Kenneth D. Bowman and Dr. Rebecca H Shin to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

Are you under a physician's care now? No___ Yes: _____
Have you ever been hospitalized or had a major operation? No___ Yes: _____
Have you ever had a serious head or neck injury? No ___ Yes: _____
Please list any medications you take: _____
Do you take, or have you taken, Phen-Fen or Redux? No ___ Yes _____
Are you on a special diet? No ___ Yes _____
Do you use tobacco? No ___ Yes _____
Do you use controlled substances? No ___ Yes _____

Women: Are you…
☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Local Anesthetics

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Anaphylaxis	☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis
☐ Anemia	☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism
☐ Arthritis/Gout	☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Scarlet Fever
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Hives or Rash	☐ Shingles
☐ Artificial Joint	☐ Excessive Thirst	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Asthma	☐ Fainting/Dizziness	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Kidney Problem	☐ Spina Bifida
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolaps	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores	☐ Heart Murmur	☐ Pain In Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/ Disease	☐ Psychiatric Care	☐ Venereal Disease
			☐ Yellow Jaundice

Have you ever had any serious illness not listed above? No ___ Yes _____

Additional Comments: _____
_____
_____
_____

Signature: _____ Date: _____

Bowman Family Dentistry PLLC

2542 Jefferson Highway, Suite 104

Waynesboro, VA 22980-9502

540-943-8545

Thank you for choosing our practice! First and foremost we are committed to the success of your dental treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

Office Visits & Office Services: Patient's dental insurance plans state that payments including co-pays and deductibles are to be collected for office visits at the time of service. Upon request, a member of our Business Office staff will review any deductibles and out of pocket expenses you are responsible for as outlined by your insurance plan. If you have not met your annual deductible, you are expected to pay for services.

Patient Cancellation Agreement: Twenty-four (24) hour notice is required for all patients cancelling or rescheduling office visits, new patient appointments and consults. If our office does not receive twenty-four (24) hour notice you may be charged a $25 fee for the missed office visit. Multiple cancellations or numerous scheduling changes may result in termination of patient treatment.

How May I Pay? We accept payment by Cash, Visa, MasterCard, Care Credit, Discover, American Express, and Check (with copy of a valid driver's license).

Acknowledgement: I have read, understand and agree to the terms as outlined above. I understand that my co-payment, co-insurance, and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable copayments and deductibles are my responsibility.

- In the event that outside collection and/or legal coast are incurred by this office to obtain payment due, responsible party agrees that they will be liable for any costs incurred.
- I authorize my insurance benefits be paid directly to Bowman Family Dentistry PLLC.
- I authorize Bowman Family Dentistry PLLC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Date Name of patient (print) Signature of Patient or Guardian

2542 Jefferson Hwy #104,
Waynesboro, VA 22980

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address:_____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above-named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____
- ❑ Other:_____

Prepared By _____

Signature _____

Date _____

Authorization for Release of Protected Health Information

Name of Patient: _____ **Date of Birth:** _____

The office of Bowman Family Dentistry is authorized to release protected health information as described below for the identified patient.

Entity to Receive Information. Check each person or class of persons that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐**Voice Messages on _____ number.**	☐**Appointment Reminders** ☐**Lab Results** ☐**Other**
☐**Spouse or Significant Other:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Other Person:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Another Person:** _____	☐**Appointment Reminders** ☐**Lab Results** ☐**Treatment Notes and Record** ☐**Discuss Treatment**
☐**Photo of patient received by patient or legal guardian** ☐**Photo taken by staff (Example: pre/post procedure)**	☐**May be posted in office** ☐**May be posted on website**

Patient Rights:

1. I have the right to revoke this authorization at any time.
2. I may inspect or copy the protected health information to be disclosed as described in this document.
3. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
4. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)