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**Divine Dentistry**

**Dr. Andrea L. Davis, DDS, PC**

**28 Pass Rd., Suite 300**

**Gulfport, MS 39507**

**228-863-4009**

**www.divinedentist.com**

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Patient Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male  Female Patient’s Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Evening  Any Time M T W Th F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Apartment #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip Code

**Referral Information**

Whom may we thank for referring you to our practice?  Another Dental Office  Yellow Pages

  Newspaper  School  Work  Another patient, friend/family  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Insurance Information

# Primary

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

 Street City State Zip Code

Insured's Employer Name: Phone Number:

Patient's relationship to insured:  Self  Spouse  Child  Step-Child  Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company’s Name, Address and Phone Number:

**Secondary**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

 Street City State Zip Code

Insured's Employer Name: Phone Number:

Patient's relationship to insured:  Self  Spouse  Child  Step-Child  Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company’s Name, Address and Phone Number:

 **Health and Dental Information**

Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

|  |
| --- |
|  Allergies\_\_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Codeine Allergy |
|  Penicillin Allergy |
|  Anemia |
|  Artificial Joints |
|  Arthritis |
|  Asthma |
|  Blood Disease |
|  Cancer |
|  Cerebral Palsy |
|  Chemo-Active |
|  Diabetes-Type I or II |
|  Dizziness |
|  Epilepsy |
|  Glaucoma |
|  Head Injuries |
|  Heart Disease |
|  Heart Murmur |
|  Hemophilia |
|  Hepatitis |
|  High Blood Pressure |
|  HIV/ AIDS |
|  Jaundice |
|  Kidney Disease |
|  Liver Disease |
|  Mental Disorders |
|  Mental Retardation |
|  Nervous Disorders |
|  Pacemaker |
|  Pregnancy |
|  Due Date\_\_\_\_\_\_\_\_\_\_\_ |
|  Radiation Treatment |
|  Respiratory Problems |
|  Rheumatic Fever |
|  Rheumatism |
|  Seizures |
|  Sickle Cell Disease |
|  Sickle Cell Trait |
|  Sinus Problems |
|  Skin Disorder(s) |
|  Stomach Problems |
|  Stroke |
|  Tuberculosis |
|  Tumors  |
|  Ulcers |
|  Other\_\_\_\_\_\_\_\_\_\_\_\_  |

• Has the above mentioned patient ever had any complications following dental treatment?  Yes  No

 If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Has the above mentioned patient been admitted to a hospital or needed emergency care during the past two years?

  Yes  No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Is the above mentioned patient now under the care of a physician?  Yes  No

 If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Are there any health problems that need further clarification?  Yes  No

 If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• **Please list any medications you are currently taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**●**Is there anything else that you feel we should know about you or your child to help improve your dental treatment and personal relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Take the Time to Check One.**

There are **4 levels of** **care** we provide in our office. We believe that each individual has the right to become as healthy as they choose to be. Please choose which level best represents the way you wish to begin your relationship with us. **(It is not uncommon to begin at one level and progress to a higher level over time.)**

**Level I - Emergency Care- Immediate Need\_\_\_\_\_\_**

I am only interested in emergency dental care for the relief of pain and/or cosmetic embarrassment. I am not very interested in thinking about the future of my teeth at this time.

**Level II – Maintenance/Preventative Care- Minimal Repair \_\_\_\_\_**

I am interested in taking an active part in the prevention of the disease process and the repair of existing problem

(example: regular cleanings, necessary fillings, etc.) . However, I am not yet ready for optimum care do to limitations of time and/or money. I understand maintenance dentistry may not be a long-term solution to my dental health.

**Level III – Optimum/Functional Care - Ideal \_\_\_\_\_**

I am interested in achieving and maintaining long-term optimum dental health with no limitations of time and/or money. I am concerned about treating the causes of dental disease, not simply the effects. I want all dental treatment provided to be the best option for maximum protection and longevity.

**Level IV – Optimum/ Esthetic Care- Cosmetic\_\_\_\_**

I am interested in achieving and maintaining long-term optimum dental health with no limitations of time and/or money. I am concerned about treating the causes of dental disease, not simply the effects, but appearance is very important to me. I would like the ideal smile with no concern for cost.

**If you could change anything about your smile, what would it be?**

 **Appointments**

Our staff goes to great lengths to provide the quality of care that we feel each of our patients deserve. When we schedule your appointments, we follow carefully planned protocols to maintain that goal. As a courtesy, our staff will call at least 48 hours in advance to confirm each of your appointments. If we are not able to reach you or you receive a voicemail, please call our office to verbally confirm your appointment time. This will help us be better prepared for your arrival. **Please understand that we may not be able to hold your appointment time if we are unable to confirm your appointment.**

We do respect our patient’s schedules and we asked that you would also have respect for our schedule and the schedule of others. Late arrivals cause us to run late for other patients. Please understand that arriving after your appointment time may result in the rescheduling of your appointment. We do understand unexpected events and emergencies can happen. Please let our office knows as soon as possible that you can not make your appointment time. If it does not interfere with other patient’s schedule we will be happy to accommodate you.

We do ask for 48 hours notice to reschedule or cancel an appointment. Multiple rescheduled or cancelled appointments may result in additional charges that would need to be paid prior to scheduling future appointments. The minimal charge for lack of notice will be $50 or an hourly rate to help defer some of the overhead expense associated with not having a patient scheduled in your time slot. Thank you for your understanding and the understanding of others. **After two broken or missed appointments, the dentist reserves the right to discontinue any additional treatment.**

**Financial Agreement**

**Our goal is to offer you payment options to finance the care you need to maintain good oral health while staying within your budget. This practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.**

**All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or with a credit card at the time services are performed.**

**Credit Cards**

For your convenience, we accept MasterCard, Visa, Discover and CareCredit.

**Extended Payments**

For patients who desire a monthly payment plan, we have made arrangements with CareCredit. There are no application fees, no down payment is necessary, and the loan can be **interest-free**. Applications are provided by our office manager and approval is provided very quickly, usually within 30 minutes.

**Dental Insurance**

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, we will file your insurance, speak on your behalf to the insurance company and accept any assignment of benefits that your insurance company will allow. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. We will estimate your patient portion by considering deductibles, maximums and the knowledgebase provided by your insurance company. Please understand that your insurance policy is a contract between you and your dental insurance company. The insurance company will not guarantee payment therefore we ask that all patients be directly responsible for all charges. If for any reason your insurance company pays less than our estimate, you are responsible for the unpaid balance. Accounts with balances over 30 days will be turned over to a collection agency. For all patients under the age of 18, the legal guardian presenting the patient for treatment is responsible for all payments to Divine Dentistry. This office does not participate in any agreements between parents or other parties. We will be happy to provide receipts and ledgers for any charges and payments for your cause.

**All Patients and Responsible Parties**

I further agree that I shall be billed unless objected to, by me, in writing, I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**Authorization and Consent**

**I agree that I have filled out these forms with the intent of honesty and I agree that it is my own responsibility to update any changes in my medical history and or conditions with each dental visit.**

**General Consent for Treatment**

 **I agree and consent to a dental examination by dentist(s) practicing under the name Divine Dentistry. I understand that additional diagnostic procedures and treatment may be recommended and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatment.**

**Release of Information**

 **I authorize Divine Dentistry to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.**

**Assignment of Insurance Benefits**

 **I authorize and request my insurance company to pay my benefits directly to Divine Dentistry.**

**Photography Release**

 **I authorize Divine Dentistry to take photographs of me to help me better understand my current dental condition and possible treatment options. I also authorize Divine Dentistry to show these photographs to other patients to better explain their treatment options (as you may be shown photographs for the same reason).**

**My signature acknowledges that:**

***I will be responsible and update any information on these forms with each dental visit.***

 ***I understand the office policy regarding Appointments.***

 ***I understand and will comply with the office Financial Policy.***

 ***I understand and agree to the General Consent to Treatment.***

 ***I authorize the Release of Information.***

 ***I assign my insurance benefits payable to Divine Dentistry.***

 ***Photographs taken of me may be shown to other patients or in advertisements.***

 ***I have been offered a copy of this office’s Notice of Privacy Practices.***

**Signature of Patient, Parent or Guardian Date**

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**Dolphin Court Lakeview Village**

 **28 Pass Road 11505 Cinema Drive, Suite 6**

 **Gulfport, MS 39507 D’Iberville, MS 39540**

**Office 228-863-4009 Fax 228-863-4358**

**Office 228-396-9000 Fax 228-396-9006**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed and was offered a copy of this office’s Notice of Privacy Practices.

I give permission to the Divine Dentistry team to discuss clinical financial

 appointment information specifically with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Please Print Name

Signature

Date

**For Office Use Only**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

* **Individual refused to sign.**
* **Communication barriers prohibited obtaining the acknowledgement.**
* **An emergency situation prevented us from obtaining acknowledgement.**
* **Other (please specify)**

**Notice of Privacy Practices**

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect immediately and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our office.

**Typical Uses and Disclosures of Health Information**

We will keep your health information confidential, using it only for the following purposes.

**Treatment:** We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentially statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations**: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and controls disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, text messages, emails, postcards or letters.

**YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $5.oo for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information; if you fell it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. You must submit a written request if there are any particular parts of this agreement that you wish to not agree to and/or if there is a particular person, business, or entity that you wish or practice not to share your information with. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**Questions and Complaints**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

**HOW TO CONTACT US**

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