PATIENT INFORMATION

Patient's Name _____ Preferred Name _____
First Middle Last

Date of Birth _____/_____/_____ Sex ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Address _____ Social Security Number _____/_____/_____
Number Street

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work Email _____

Would you like appointment reminders by: ☐ phone ☐ text ☐ Email

Employer _____ Position _____

Who to contact in case of emergency _____ Phone Number (_____) _____

Whom may we thank for referring you/How did you find out about us? _____
Please fill out

Where have you seen us? Please check all that apply:

☐ YellowPages ☐ YellowBook ☐ Google
☐ Radio ☐ FaceBook ☐ Billboard
☐ New Albany Magazine ☐ Instagram ☐ Invitation
☐ New Albany Gazette ☐ Sporting Event ☐ Website _____

ACCOUNT INFORMATION

Who is financially responsible for this account? _____
First Middle Last

Relationship to patient? ☐ Self **(skip to insurance information**) ☐ Parent ☐ Child ☐ Spouse ☐ Other

Date of Birth ____/_____/_____ Sex ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Address _____ Social Security Number _____/_____/_____
Number Street

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

DENTAL INSURANCE INFORMATION

Subscriber's Name _____ Employer _____
First Middle Last

Full Name of Dental Insurance Company _____

Employer ID Number/Contract Number _____ Group Number _____

Dental Insurance Company Address _____

Dental Insurance Company Phone Number ( ) _____ alt ( ) _____

If dental insurance is through the patient or financially responsible party, do not fill out the portion below.

Subscriber's relationship to patient? ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other

Date of Birth ____/_____/_____ Sex ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐ Widowed

Address _____ Social Security Number _____/_____/_____
Number Street

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

MEDICAL HISTORY

Your answers to the following questions are considered completely confidential. You may be asked questions about your responses to this questionnaire during your visit.

Are you under a physician's care now?	☐ Yes	☐ No	Explain: _____
Have you ever been hospitalized or had a major operation?	☐ Yes	☐ No	Explain: _____
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	Explain: _____
Are you taking any medications including non-prescription?	☐ Yes	☐ No	Explain: _____
Do you take a blood thinner or daily Aspirin?	☐ Yes	☐ No	Explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	Explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes	☐ No	Explain:_____
Are you on a special diet?	☐ Yes	☐ No	Explain: _____
Do you use tobacco?	☐ Yes	☐ No	Explain: _____
Do you use controlled substances?	☐ Yes	☐ No	Explain: _____

Women: ☐ Are you pregnant or trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal
☐ Latex ☐ Local Anesthetics ☐ Sulfa Drugs ☐ Other _____

Do you have, or have you had, any of the following? Please circle or highlight all that apply.

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, explain

_____

Do you take or have you been told by a physician to take an antibiotic <u>Pre-Medication</u> 1 hour prior to dental treatment? ☐Yes ☐ No

I hereby consent to dental treatment at Mercier Dental. I understand that my treatment options depend on my current health conditions. I am responsible for discussing any risks to my health with the staff at Mercier Dental before my treatment begins.

Signature of Patient or Guardian _____ Date _____

PAYMENT PREFERENCES Please place an X next to one of the following.

☐ I do not have insurance, or my insurance company reimburses me directly, and I will pay in full with cash, personal check or credit card. We accept Visa, MasterCard, Discover or American Express. For payment amounts over $300, we offer a payment-in-full courtesy of 5% off with cash or check and 2% off with a credit or debit card. We also offer a 10% off senior citizen courtesy for patients 65 years or older (the senior citizen courtesy is not stackable with any other courtesy). We will happily process any claims for insurance companies that reimburse you directly after you have paid in full for your services.

Mercier Dental now offers our own Dental Maintenance Plan to patients without insurance. This plan offers affordable payment options for preventative procedures and discounted rates for treatment. Please ask us for more information if you are interested in our Dental Maintenance Plan.

☐ I do not have insurance, or my insurance company reimburses me directly, and will pay using Wells Fargo or CareCredit. Wells Fargo and CareCredit are an outside financing company that requires no down payment, but does require a credit check. We offer interest free payment plans for up to 6 months with fees totaling between $200 and $999 and up to 12 months with fees totaling $1,000 or more. Please note that CareCredit has recently changed their policies and now charges 14.90% interest for fees totaling less than $200. If you are interested in Wells Fargo or CareCredit, please ask us for more information.
Wells Fargo and/or CareCredit must be approved or your Wells Fargo and/or CareCredit number provided to us prior to the start of treatment.

☐ I have insurance and I will pay my estimated co-pays and/or deductibles on the date of my visit using cash, a personal check, credit card, or CareCredit. I understand that the staff at Mercier Dental makes every effort to provide an accurate estimate of my deductibles and co-pays, but it is **just an estimate** and I am responsible for paying any amounts insurance does not pay.

For your convenience, you may provide your credit card or CareCredit payment information below. By doing so, you are authorizing Mercier Dental to charge your credit card or CareCredit account for any procedures or treatments performed. **Your signature below also authorizes us to charge your credit card or CareCredit account the amount of any balance remaining after insurance has paid their portion.**

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ CareCredit

Card Number _____ Expiration Date _____ Security Code _____

PLEASE READ CAREFULLY: Mercier Dental requires payment for services on the date your services are received. We are happy to process any insurance claims at no charge as a courtesy to you, but please note that your estimated co-pays and/or deductibles are due on the date of service. We want you to understand that your dental plan will probably not cover the total cost of your services and it is your responsibility to familiarize yourself the specifications of your dental plan's coverage. Your dental plan is a contract between you and your insurance company or employer and Mercier Dental is not always a part of that contract. The amount your insurance company pays for services is based on that specific company's fee schedule and are usually different from the fee schedule used by this office. **Please keep in mind that any estimate we provide is ONLY AN ESTIMATE and you are responsible for all fees in their entirety.** We are not always able to answer specific questions regarding your benefits because of your insurance company's privacy regulations or policies. If an account balance has not been paid within 60 days from the date of service or from payment or non-payment of insurance, we will begin charging finance charges of 1.5% per month (18% annually) on the unpaid balance. Finance charges will accrue every month on the unpaid balance until the account has been paid in full.

Due to delays with insurance companies, we ask that if your insurance company has not paid for your visit within 90 days, you cover your balance and seek reimbursement directly from your insurance company. We are proud that our fees reflect the time the doctor spends with each patient as well as the overall quality of the care and service that we provide in our practice.

I have read the above and I certify that this information is accurate and true to the best of my knowledge. I understand that I am responsible for paying the fee of services rendered, including reasonable attorney's fees and cost of collection in the event of default.

Signature of Patient or Person Financially Responsible _____Date _____

MERCIER DENTAL
230 STARLYN AVENUE
NEW ALBANY, MS 38652
662-534-5252

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____
_____
_____

WARRANTY ON CROWN, BRIDGES, AND VENEERS

- We proudly warranty the restorative work completed in our office. We want you to have confidence in our dentistry and its longevity.

- Our warranty will replace any crowns, bridges, and veneers that the doctor finds unacceptable.

- It is replaced at no charge if defective before two years. Between two and four years, it is replaced at half price. The warranty expires after four years.

- Our warranty will not replace restorations that have failed due to new decay in the involved tooth or teeth.

- The above warranty will be honored ONLY IF you maintain regular hygiene intervals as recommended by our office. We cannot warranty what we are not actively helping you maintain.

Patient:_____

Date:_____

Mercier Dental

Cancellation Policy

At Mercier Dental, we understand that your life is busy and your time is precious to you. We will make every effort that your appointment begins at its scheduled time. We have that same standard for ALL of our patients. Because we are respectful of your time, we ask that you be respectful of our time, too. We will make several attempts to confirm your appointment within the week prior to your appointment.

Please understand that your appointment represents a time committed to YOUR care. Our office will try to notify you of any appointment changes more than 24 hours prior. We ask that you notify our office more than 24 hours prior if you are unable to come.
Failure to do so will result in a $50 no-show fee, and repeated no-shows without notification may result in dismissal from the practice.

Please list the phone number(s) where you can be reached to confirm your appointment:

_____

I have read and agreed to the cancellation policy:

X _____

This Form is educational only,
does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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 treatment to you.

Payment: We may use and disclose your health information 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. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, 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 Health-Related Services: 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, postcards, or letters)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, 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. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0___ for each page, $0___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, 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.

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. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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

Contact Officer: Jennifer Farrar (Office Manager)

Telephone: (662) 534-5252 Fax: (662) 534-5052

E-mail: jennifer@mercierdental.com

Address: 230 Starlyn Ave, New Albany, MS 38652

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