BOLLEN + MANSFIELD
FAMILY DENTISTRY

Bollen & Mansfield Dental Clinic
809 Marshall Road, Jacksonville, AR 72076
(501)982-4444 • www.bollenandmansfield.com

Patient Information

Name: _____
Preferred Name: _____
Birthdate: _____
Social Security #: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Sex: ☐ Male ☐ Female
Marital Status: ☐ S ☐ M ☐ W ☐ D Other Family
Members seen in the office: include name and relation (parent, child, spouse)

_____
_____
_____

Referred by: _____

Email: _____

Spouse/Parent/Emergency Info

Spouse (***Parent's/Guardian's name if under 18***):

_____
Spouse's Employer: _____
Spouse's Date of Birth: _____

In case of an Emergency, please contact:

Name: _____
Relation to patient: _____
Home Phone: _____
Work Phone: _____
Other Phone: _____

Employer Information

Employer: _____
Employer's Address: _____

_____

_____
Employer Phone #: _____

Primary Dental Insurance

Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone Number: _____
Group #: _____
Policy #: _____

Insured Name: _____
Patient's relation to insured: _____
Insured's Birthdate: _____
Insured's SS#: _____
Insured's Employer: _____

Person Responsible for Account
MUST FILL OUT and SIGN!

Name: _____
Billing Address: _____
Home #: _____ Work #: _____
SS#: _____

To the best of my knowledge, all above answers are correct. I am aware that **I am responsible for all charges for services rendered on this account and that payment is due at the time of the service. I authorize the assignment of insurance benefits to the dentists.**

Date: _____
Signature: _____

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Name: _____

Do you have, or have you had, any of the following diseases or medical problems?

AIDS/HIV Positive	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	**Pain in Jaw Joints**	☐ Y	☐ N
Allergies/Sinus Trouble	☐ Y	☐ N	Heart Pacemaker	☐ Y	☐ N	Psychiatric Treatment	☐ Y	☐ N
Arthritis/Gout	☐ Y	☐ N	Heart Disease	☐ Y	☐ N	Radiation Treatment	☐ Y	☐ N
Artificial Heart Valve	☐ Y	☐ N	**Hemophilia**	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Artificial Joint	☐ Y	☐ N	Hepatitis	☐ Y	☐ N	Stroke	☐ Y	☐ N
Asthma	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N	Thyroid Disease	☐ Y	☐ N
Cancer/Chemo	☐ Y	☐ N	Kidney Problems	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Liver Problems	☐ Y	☐ N	Currently Pregnant or Nursing	☐ Y	☐ N
Drug Alcohol Addiction	☐ Y	☐ N	Lung Disease	☐ Y	☐ N	Taking Birth Control	☐ Y	☐ N
Epilepsy/Seizures	☐ Y	☐ N	**Mitral Valve Prolapse**	☐ Y	☐ N	Periodontal-Gum Surgery	☐ Y	☐ N
Heart Attack	☐ Y	☐ N	**Osteoporosis**	☐ Y	☐ N	Complications of dental treatment	☐ Y	☐ N

If you answered yes to any of the above questions, please explain further: _____

_____

_____

Are you **taking any medications** or over the counter drugs? ☐ Y ☐ N

If yes, please list each one: _____

_____

Are you taking any medications for Osteoporosis? ☐ Y ☐ N **List meds**: _____

Are you taking any **medications to thin your blood**? ☐ Y ☐ N **List meds**: _____

Physician's Name: _____ Phone: _____ Location: _____

Please list any serious medical conditions, **hospitalization in the last two years**, impending operations, or other medical or dental information that may possibly affect your dental treatment: _____

_____

_____

Are you allergic to any of the following?

Latex ☐ Y ☐ N *Codeine* ☐ Y ☐ N *Aspirin* ☐ Y ☐ N *Dental Anesthetics* ☐ Y ☐ N *Penicillin* ☐ Y ☐ N **Other:**

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence**. It is my responsibility to inform this office of any changes in my medical status or personal information**. I authorize the dental staff of Bollen & Mansfield to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize the release of any dental and medical information necessary to process insurance claims or to aid in the treatment by a specialist.

Signature: _____ Date: _____

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FINANCIAL AGREEMENT

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. Please read and sign prior to seeing the doctor.

- We accept cash, check, VISA, Master Card, American Express and Discover.
- We also provide a third party interest free payment plan through CareCredit®.

Payment is due at the time of service. We must emphasize that as your dental care provider, **our relationship is with YOU, our patient, not your insurance company**. Your insurance policy is a contract between you, your employer, and your insurance company. As a courtesy to you we will help you process all your insurance claims**. Please understand that we will provide an insurance estimate to you, however, it is NOT a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid.** We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment in 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time. We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payments directly to our office. We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid.

We thank you for the opportunity to serve your dental care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office**. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.** I futher understand that a finance (1.5%), rebilling, collection charge (30%) and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to moblie devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, withour reimbursement from us.

Regarding minors: The adult accompanying a minor will be responsible for payment of services**. Minors must always be accompanied by an adult.**

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

Signature _____ Date _____

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Appointment cancellation Policy

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting***. As a result, your appointment time in this office is reserved exclusively for you.***

We reserve the right to charge patients who do not call with adequate notice, or who fail to keep their scheduled appointments.

How to Cancel Your Appointment
To be respectful of the needs of all Dr. Mansfield's patients, if it is necessary to cancel your reserved appointment, **we require that you contact our office 48 hours in advance**. Our voicemail system runs 24/7. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care.

No Show Policy
If you do not cancel with enough notice or do not show at all for your appointment it is considered a 'No Show'. No shows inconvenience patients who need access to dental care in a timely manner. **Last minute/late cancellations are considered 'no show' appointments.**

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a 'no show'. Your 1st missed appointment will be no charge **as a courtesy** as we know things can happen. **Your 2nd will be charged a $25 fee. Your 3rd is $50.** *If we block a large amount of time for a work appointment w/ the doctor and it's missed, it could be a $50 charge*. If there is a fourth 'no show' it could result in suspension of services or dismissal from our dental practice.

How to Cancel Your Appointment

In order to be respectful of the needs of all Dr. Bollen and Mansfield's patients, if it is necessary to cancel your reserved appointment **we require that you contact our office by 10:00am two (2) working days in advance**. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care.

No Show Policy

If you do not cancel with enough notice or do not show at all for your appointment it is considered a 'No Show'. No shows inconvenience patients who need access to dental care in a timely manner. **Last minute/late cancellations are considered 'no show' appointments.**

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a 'no show'. The will be no charge **as a courtesy** as we know things can happen. **Your third 'no show' will be charged a $50 fee.** If there is a fourth 'no show' it could result in suspension of services or dismissal from our dental practice.

By signing below, I certify that I have read and understand the terms and conditions of Bollen and Mansfield Dental Clinic appointment cancellation policy:

_____ _____

Signature Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____