Van Hemert Family Dentistry

320 E 3rd St. N, Newton, IA 50208

Financial Arrangements

Thank you for choosing our office for your dental needs. We are committed to providing you with the best possible care. If you have dental insurance, we are willing to try and help you recieve your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We will gladly discuss your proposed treatment and, to the best of our knowledge, answer any questions relating to your insurance.

Our office is committed to helping you maximize your benefits. Insurance policies vary greatly, therefore, owing to the complexities of insurance contracts we can only estimate in good faith and not guarantee coverage. We accept assignment of benefit from many insurance companies. In the event we do accept assignment of benefits and your insurance company has not paid in full within 90 days, the balance will be transferred to your account. Please be aware that some, perhaps all, of the services provided may non-covered services and not considered reasonable and customary under the terms of your insurance policy. This is not a reflection on the necessity or advisability of the treatment. Your insurance is a contract between you and the insurance company. We will try and assist you in obtaining maximum benefit; however, we are not a party to that contract. It is ultimately your responsibility to know and understand your contractual obligations as an insured person under your specific contract.

You may use any of the following options to help you obtain desired dental treatment:

Cash, check or credit card for payment in full at time of service
You may apply for a credit card through Care Credit. Upon approval, you may choose monthly payments for up to six (6) months with no interest.
If you have dental insurance, we will be glad to send in the claim as a courtesy to you and accept assignment of benefits. You are responsible for any unpaid balance.
An in house two (2) payment option for major procedures such as dentures and bridges. 50% payment is required at the impression appointment and 50% at the seat appointment (subject to approval).
For treatment plans over $500, you may make three (3) or less scheduled monthly payments if placed on your credit card (subject to approval).

If there is a credit on your account a refund check will be issued for amounts in excess of $20.00. For amounts less than $20.00 the credit will remain on your account.
Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee.
Outstanding balances over 60 days will be subject to a finance charge of 1.5% monthly. Patients with outstanding balances on their account past 60 days will be seen on an emergency basis only until resolution of your bill.
Outstanding balances over 90 days may be turned over to a collections agency and subject to any additional collection fees.
We request 24 hours notice if you must change or cancel your appointment. Repeated late cancellations or appointment failure will be subject to a $30.00 late cancellation fee.

“I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read and understand all the information on this sheet.”

NAME:_____

SIGNATURE: _____ DATE: _____

van hemert
FAMILY DENTISTRY

320 E 3rd St. N, Newton, IA 50208
Ph: 641.792.4234 | Fax: 641.792.1157
www.vanhemertfamilydentistry.com

Authorize Release of Information

Many of our patients allow family members and close friends such as their spouses, parents, friends or others to call and request the results of exams or procedures from their dental visits or payment and billing information. Under the requirements for HIPAA (Health Insurance Portability and Accountability Act) we are not allowed to give this information to them without your consent. If you wish to have your dental exam/treatment/payment information and needs released to family members or close friends you must sign this form. Signing this form will only give consent to release information to the people listed below.

You have the right to revoke this consent, in writing, except where we have already made disclosures with your prior consent.

I authorize Van Hemert Family Dentistry, PC to release my results of exams, procedures, tests, reports in addition to billing information, payments and financial arrangements to the following individuals:

1.)_____ Relationship to Patient _____

2.)_____ Relationship to Patient _____

3.) _____ Relationship to Patient _____

Signature of Patient/Guardian: _____

Print Name: _____ Date: _____

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You May Refuse to Sign This Acknowledgment

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)

_____

_____

_____

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Patient Information

Patient Name: _____
Last First MI Preferred Nickname

Mailing Address: _____
Address City State Zip

Email Address: _____

Gender: _____ **Birth date:**____/___/____ **Social Security Number:**_____

Home Phone: _____ Cell Phone: _____

Best way to Confirm Appointments: _____ Text ____ E-mail _____Phone: (circle one) HOME CELL

In case of emergency, please notify:_____ phone: _____

Parents/Guardians if Under 18 (please print names):_____

Employer: _____ Work Phone #: _____

Have you seen Dr. Van Hemert professionally before? YES (Where _____) NO

Dental Insurance

Primary Carrier:
Name of Insured: _____ Relationship to Patient: _____

Insurance Co. Name: _____ Policy Number: _____

Insured's Employer Name: _____Social Security Number: _____

Birth Date of Insured: _____/_____/_____
Secondary Carrier:
Name of Insured: _____ Relationship to Patient: _____

Insurance Co. Name: _____ Policy Number: _____

Insured's Employer Name: _____Social Security Number: _____

Birth Date of Insured: _____/_____/_____

Insurance Authorization Statement:

I hereby authorize payments directly to Van Hemert Family Dentistry, PC of the insurance benefits otherwise payable to me. This is a direct assignment of my rights and benefits under this policy. Our dental office is only able to estimate the dental insurance payment. I understand that I am responsible for all costs regardless of my insurance coverage. The information on this page is correct to the best of my knowledge.

Patient or Guardian Signature: _____ **Date:** _____
Print Name: _____

Van Hemert Family Dentistry

Medical and Dental History and Information

Patient Name: _____ Birthdate: _____

Address: _____ Primary Phone: _____

Name of Physician: _____ Primary Pharmacy: _____

Are you currently under the care of a physician? YES NO

Please explain if yes: _____

Do you currently or have you ever had the following medical conditions?

YES	NO	Heart Disease	YES	NO	Stomach Ulcer/Frequent Heartburn
YES	NO	Artificial Heart Valve, Damaged Valve	YES	NO	Eating Disorder
YES	NO	Chest Pain/Angina	YES	NO	Kidney Problems
YES	NO	Rheumatic Heart Disease	YES	NO	Diabetes
YES	NO	Congestive Heart Failure	YES	NO	Thyroid Disease
YES	NO	Heart Attack/Stroke: (if yes date: _____)	YES	NO	Artificial Joints (if yes, date:_____)
YES	NO	Heart Surgery, Pacemaker, Defibrillator	YES	NO	Arthritis or Dexterity Problems
YES	NO	High Blood Pressure	YES	NO	Epilepsy/Seizures/Fainting
YES	NO	History of Endocarditis	YES	NO	Decreased Immunity (drug, disease, transplant)
YES	NO	Blood Disorders	YES	NO	Cancer or Leukemia (type: _____)
YES	NO	Are you taking blood thinners?	YES	NO	Chemotherapy (date: _____)
			YES	NO	Radiation (if yes: head/neck? Yes No)
YES	NO	Blood transfusion	YES	NO	Lupus
YES	NO	Anemia	YES	NO	Spleen Removal
YES	NO	Hemophilia/Abnormally Prolonged Bleeding	YES	NO	HIV/AIDS
YES	NO	Liver Disease	YES	NO	Hearing Impairment
YES	NO	Jaundice	YES	NO	Glaucoma
YES	NO	Hepatitis (if yes: A, B, C, other)	YES	NO	Infectious Diseases
YES	NO	Respiratory Disease	YES	NO	Alcohol Abuse
YES	NO	Asthma	YES	NO	Substance Abuse
YES	NO	Emphysema	YES	NO	Drugs for Osteoporosis
			YES	NO	History of IV or oral Bisphosphonates
YES	NO	Tuberculosis	YES	NO	Tobacco Use
YES	NO	Sinus Problems	YES	NO	Behavioral/Mental Conditions
YES	NO	Have you ever had major surgery?	YES	NO	Any other medical conditions?
(if yes, what surgery and date: _____)			(Explain: _____)		

Women: Are you pregnant? YES NO Due date: _____

Are you nursing? YES NO

ALLERGIES:

Are you allergic to or suffer ill effects from any of the following:

☐ Penicillin ☐ Latex/Rubber ☐ Aspirin or Ibuprofen ☐ Codeine or narcotics ☐ Dental Anesthesia

☐ Metals (example: Nickel, etc) ☐ Antibiotics (if so, which: _____)

☐ Other allergies:_____

Medications: Please list any medications, including OTC, "natural" or supplement

_____

_____

_____

What is your primary dental concern? _____

Please answer the following:

YES	NO	Do you feel pain in any of your teeth?	YES	NO	Do you have frequent headaches?
YES	NO	Are your teeth sensitive to sweet, hot or cold?	YES	NO	Do you get sinus pain or pressure?
YES	NO	Are you aware of any broken teeth?	YES	NO	Do you have popping or clicking in jaw joints?
YES	NO	Do you have any sores or lumps in your mouth?	YES	NO	Do you have jaw pain (joint, ear, side of face)?
YES	NO	Do your gums bleed while brushing/flossing?	YES	NO	Do you clench or grind your teeth?
YES	NO	Have you been treated for “gum disease?”	YES	NO	Difficulty in opening or closing?
YES	NO	Do your gums feel swollen or tender?	YES	NO	Have you had any head, neck or jaw injuries?
YES	NO	Have you had any difficult extractions before?	YES	NO	Difficulty in chewing?
YES	NO	Do you have any loose teeth?	YES	NO	Do you wear dentures or partials?
YES	NO	Do you use tobacco?	YES	NO	Have you had braces?
YES	NO	Do you have bad breath or a bad taste in your mouth?			
YES	NO	Have either of your parents lost their teeth to gum disease or been treated for gum disease?			
YES	NO	Have you ever received oral hygiene instructions regarding the care of your teeth and gums?			

I authorize and give consent to perform dental services agreed between the doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthetics and other medication as needed. I certify to the statements regarding my medical and dental condition.

For the purpose of teaching, research, peer review and scientific publication, the dentist may use photographs, radiographs or other diagnostic materials. The identity of the patients will remain anonymous. The patient may view this material for consent and refuse this request.

Signature: _____ **Print name:** _____

Date: _____

Reviewed by Patient:

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____