Welcome! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- We work with only one patient at a time, and do not double book. The time that you reserve with us is yours and yours alone.
- We strive to be thorough in everything we do, taking the time to be the best we can be.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you. This will take approximately 90 minutes.

Enclosed you will find our new patient information form. Please fill this out and bring it with you to your first appointment along a list of any medications that you take.

We look forward to meeting you.

Sincerely,

Dr's Richard and Erick Anderson

P.S. Please visit our website at www.andersonsmile.com to learn more about us!
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____________________________________________

Relationship to Patient: ___________________ Date:_______________

Signature: __________________________________________________
Facts About Dental Insurance

As an optimal-care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

**Fact #1:** Your dental insurance is based upon a contract between your employer and the insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or the insurance company directly.

**Fact #2:** Dental insurance benefits differ greatly from traditional medical health insurance benefits and can vary quite a bit from plan to plan. When dental insurance plans first appeared in the early 1970’s most plans had a yearly maximum of $1000. Today, some 30+ years later, most plans still have an annual maximum of $1000. That the premiums remained the same, allowing for a conservative yearly rate of inflation, your yearly plan maximums should be in excess of $4500 today. Your premiums have increased, but your benefits have not. Therefore, dental insurance was never set-up to cover your services 100%; it is only an aid.

**Fact #3:** You may receive a notification from your insurance company stating that dental fees are "higher than usual and customary." Insurance companies never reveal how they determine "usual, customary and reasonable" (UCR) fees. A recent survey done in the state of Washington found at least eight different UCR fee schedules for one zip code in the Seattle area. The fees are somehow determined by taking "a percentage" of an average fee for a particular procedure in a geographic area. Average has been defined as "the worst of the best" or "the best of the worst." We do not provide average dentistry nor do we charge average fees.

**Fact #4:** Many plans tell their participants that they will be covered "up to 80% or up to 100%," but do not clearly specify plan fee schedule allowances, annual maximums, or limitations. It is more realistic to expect dental insurance to cover 35 to 50 of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer puts in, less the profits of the insurance company.

**Fact #5:** Many routine dental services are not covered by insurance companies. This does not mean they aren't necessary or appropriate, just not covered.

We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure that you get every benefit dollar you are entitled to. However, the treatment we recommend and the fees we charge will always be based on your individual need, not your insurance coverage. The ultimate decision as to what will be done and how fast we proceed will always be made by you. Based on your decision, we will discuss the total cost of treatment and what assistance you can expect from your dental insurance. ‘All arrangements are strictly between you and our office. The full responsibility for payment of services rendered will always be with you.
Patient Information

Name_________________________ Birthdate_________________________ Soc. Sec. # ______________________
Address_________________________ City_________________________ State_____ Zip_________________
Home_________________________ Cell_________________________ Work__________________________

Circle Appropriate option: Female      Male    Single    Married    Divorced    Widowed

Patient’s or Parent’s Employer_________________________________ Work Phone________________________

Business Address_________________________ City_________________________ State______ Zip__________
Spouse or Parent’s Name___________________ Employer___________________ Work Phone__________________
Email address_____________________________________ Emergency Contact______________________________
Whom May We Thank for Referring You?

Responsible Party

Person Responsible for Account_________________________________ Relationship to Patient_______________
Address_____________________________________________________ Social Security # _________________
Birthdate_________________________ Work Phone__________________ Home Phone_____________________

Insurance Information

Name of Insured_____________________ Relationship to Patient______________ Insured Birthdate____________
Social Security #_________________ Employer___________________________ Insurance Co._______________
Ins. Co. Address______________________ Ins Co Phone #_______________________ Group #________________

If you have secondary insurance coverage please complete the following:

Name of Insured_____________________ Relationship to Patient______________ Insured Birthdate____________
Social Security #_________________ Employer___________________________ Insurance Co._______________
Ins. Co. Address______________________ Ins Co Phone #_______________________ Group #________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to any advisable and necessary dental treatment to be administered by the dentist or staff for diagnostic purposes or dental restoration.

X________________________________________________________________________________________________________
Signature of patient or parent if minor        Date
Patient Medical History

Are you under medical treatment now? .................................................. Y       N

Have you ever been hospitalized for any surgical operation or serious illness? ............................................. Y       N

Are you taking any medication(s) including Fosomax (i.e. bisphosphonates) medications? ............................................. Y       N

If yes, what medication(s) are you taking? ……………………………………………………. …

Do you use tobacco? .................................................. Y       N

Do you use alcohol or drugs? .................................................. Y       N

Have you ever taken Phen-Fen or Redux? .................................................. Y       N

Are you allergic to or had any reaction to the following?

- Local Anesthetics (e.g. novocaine) .................................................. Y       N
- Penicillin or Antibiotics .................................................. Y       N
- Sulfur Drugs .................................................. Y       N
- Latex .................................................. Y       N
- Sedatives .................................................. Y       N
- Codeine .................................................. Y       N
- Aspirin .................................................. Y       N
- Metal or Acrylic .................................................. Y       N
- Other: …………………………………………………………….. …

Women Only:

a) Are you pregnant? .................................................. Y       N
b) Are you nursing? .................................................. Y       N
c) Are you taking birth control pills? .................................................. Y       N

Have you ever been diagnosed with any of the following:

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

Office Hours

Our office is open Monday through Thursday from 8 a.m. to 5 p.m. A short lunch break is taken, and does vary, based upon our patient needs for that day.

Appointment/Cancellation Policy

We are committed to providing the highest standard of personalized dental care with a gentle, efficient, and professional manner. We value the time our patients set aside for their dental needs, therefore we request that patients notify us of cancellations or reschedules forty-eight (48) hours prior to the scheduled appointment. This allows our office to meet the dental needs of other patients who are waiting for care. If an emergency arises, as they often do, and a patient is unable to keep their appointment, our office requires communication that the appointment will be missed and rescheduled. We understand how valuable your time is, our office strives to accommodate your scheduling needs, but we do ask that you be respectful of our time as well, by providing as much notice as possible if you do need to make any changes to an already scheduled appointment.

Financial Policy

To maintain fair and ethical standards, our fees are the same for everyone, whether you have insurance or not. We accept assignment of insurance benefits; as a courtesy we will submit your dental claim on your behalf. The patient’s co-payment and/or deductible, as well as your estimated portion is expected at time of service, unless other arrangements have been made in advance with our financial coordinator. We accept Visa, MasterCard, Discover, CareCredit, personal checks, and cash. We do stress that insurance is an agreement between the individual and their respective insurance company. The ultimate responsibility of payment for professional services remains that of the patient. However, the final responsibility of the account and total understanding of insurance coverage specifics is the patient’s.

In the event that any account balances go overdue 90 days +, will be assessed a monthly finance charge of 18% APR. I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay an additional 35 % of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection) plus any court costs and attorney’s fees incurred in connection with the collection of my account.

____________________________________  ______________________
Patient Signature (or responsible party)                                Date