Daniel J. Fay DMD, PA

Daniel J Fay D.M.D. & M. Jamie Moeller, D.D.S.
748 S. New Street
Dover, DE 19904

Patient Name:	**Guarantor Name:** **D.O.B.:**
Address:	**Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Home#: **Cell#:** **Email:**	**Home# :** **Cell# :** **Guarantor S.S. #**
D.O.B.: SS#:	
Single Married Other **Gender on insurance policy: Female Male** **Primary Care Physician:** **Phone Number:**	**Employer:** **Phone Number:** **Occupation:**

***Emergency Contact*: _____ Telephone _____**

PRIMARY DENTAL INSURANCE **Name of Company:** **Policyholder's Name**: **Member ID #** **Grp#**	**SECONDARY DENTAL INSURANCE** **Name of Company:** **Policyholder's Name**: **Member ID#** **Grp#**
Policyholder's SS#:	**Policyholder's SS#:**
Policyholder's DOB:	**Policyholder's DOB:**
Employer:	**Employer**:
Relationship to Policyholder: **Self Child Spouse Other: _____**	**Relationship to Policyholder:** **Self Child Spouse Other: _____**
SECONDARY MEDICAL INSURANCE **Name of Company:** **Policyholder's Name**: **Member ID #** **Grp#**	**SECONDARY DENTAL INSURANCE** **Name of Company:** **Policyholder's Name**: **Member ID#** **Grp#**
Policyholder's SS#:	**Policyholder's SS#:**
Policyholder's DOB:	**Policyholder's DOB:**
Employer:	**Employer**:
Relationship to Policyholder: **Self Child Spouse Other: _____**	**Relationship to Policyholder:** **Self Child Spouse Other: _____**

FULL PAYMENT OR INSURANCE COPAY IS DUE AT THE TIME OF SERVICE

DUE TO NEW LAW, WE NOW NEED WRITTEN PERMISSION FROM YOU (the patient or parent/legal guardian of a minor) to leave messages on an answering machine, with someone in the household, or workplace about your appointments. By signing below, you give permission to call.

SIGNATURE _____ DATE_____

Daniel J. Fay DMD, PA

Daniel J Fay D.M.D. & M. Jamie Moeller, D.D.S.
748 S. New Street
Dover, DE 19904

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Daniel J. Fay DMD, PA may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Daniel J. Fay DMD, PA'S Notice of Privacy Practices for more complete descriptions of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Daniel J. Fay DMD, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Daniel J. Fay DMD, PA at 748 S. New St. Dover, DE 19904.

With my consent, Daniel J. Fay DMD, PA may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Daniel J. Fay DMD, PA may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment cards, insurance items, healthcare forms, and patient statements if they are addressed to the individual or marked personal and confidential.

I have the right to request that Daniel J. Fay DMD, PA restrict how it uses or discloses my PHI to carry out treatment, payment, and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Daniel J. Fay DMD, PA use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior request. If I do not sign this consent, Daniel J. Fay D.M.D. may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Legal guardian **Printed Name of Patient or Legal guardian** **Date**

_____

Relationship to Patient

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES
By signing this authorization, I authorize Daniel J. Fay DMD, PA to use and/ or disclose certain protected health information about me to or for the party or parties listed below.
This authorization permits Daniel J. Fay DMD, PA to use or disclose to: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Daniel J. Fay DMD, PA has noted in reliance upon this authorization. My written revocation must be submitted to Daniel J. Fay D.M.D. at 748 S. New Street, Dover, DE 19904.

_____ _____ _____

Signature of Patient or Legal guardian **Printed Name of Patient or Legal guardian** **Date**

_____

Relationship to Patient

Daniel J. Fay DMD, PA

HEALTH HISTORY

Patient Name: _____ Date Of Birth: _____
Preferred Pharmacy: _____ Location of pharmacy (zip code): _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what?_____
   Date of last medical exam?_____Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?

SECOND SECTION:

18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No **Allergies to**: **foods ☐, medications ☐, latex ☐?**
    Please list allergies:_____
39. Yes No Family history of diabetes, heart problems, tumors?

SECOND SECTION:

40. Yes No AIDS, HIV, HEPATITIS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Sleep Apnea?
51. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

52. Yes No Psychiatric care?
53. Yes No Radiation treatments?
54. Yes No Chemotherapy?
55. Yes No Prosthetic heart valve?
56. Yes No Artificial joint?

SECOND SECTION:

57. Yes No Hospitalization?
58. Yes No Blood transfusions?
59. Yes No Surgeries?
60. Yes No Pacemaker?
61. Yes No Contact lenses?

HEALH HISTORY CONTINUED:

V. ARE YOU TAKING:

62. Yes No Recreational drugs?
63. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
64. Yes No Tobacco in any form?
65. Yes No Alcohol?

Please list medications: _____

VI. WOMEN ONLY:

66. Yes No Are you or could you be pregnant or nursing?
67. Yes No Taking birth control pills?

VII. ALL PATIENTS:

68. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient OR Legal Guardian signature: _____ Date: _____

RECALL REVIEW:

1. Patient/Legal Guardian signature: _____ Date: _____

Daniel J Fay DMD, PA

We are committed to providing you the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities to our practice.

PATIENTS WITH INSURANCE COVERAGE

Your dental benefits are a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients maximize their coverage, but the ultimate responsibility of understanding the specifics of your coverage is yours.

- We will submit the claim to your insurance carrier as a courtesy to you. However, you are responsible for the payment of the account, and RESPONSIBLE FOR RESOLVING ANY PROBLEMS WITH YOUR INSURANCE COMPANY.
- If we are contracted with your insurance company, (in network) you are responsible only for the approved fee as determined by your plan. Daniel J Fay DMD, PA will collect your ESTIMATED portion at the time of service. If your insurance pays less than we estimated, you will be responsible to pay the difference. If we over estimated and you are due a refund-we can apply it as an account credit or Dr. Fay will write you a check.
- If we are not contracted (out of network) with your insurance provider, we will submit the claim to your insurance for your reimbursement. You will be responsible for payment in full at the time of service.
- We will check with your insurance carrier for your benefits and give you an **ESTIMATE** of the fee for your service(s) prior to your appointment. However, the estimate is not a guarantee until the claim is finalized with your insurance company and any remaining balance will be billed to you as your responsibility. Sometimes there is a COINSURANCE, DEDUCTIBLE or BALANCE DUE FOR NON-COVERED SERVICES after the claim is finalized regardless of what is told to our staff by the insurance company. ANY ESTIMATES ARE NOT A GUARANTEE.
- If your insurance company has not paid your claim within 90 days after submission, you may be required to pay for the services rendered. If a payment is received later from the insurance company, it will be credited to the account and refunded accordingly.

FINANCIAL/SCHEDULING TERMS

- Appointments that are canceled with less than 24 business hours' notice are subject to a $50 cancellation fee per hour scheduled. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor. These fees will need to be paid before any appointments will be rescheduled.
- Any check that is returned by a bank for Non-Sufficient Funds are subject to a minimum $40 processing charge. This fee is the responsibility of the patient/guarantor.
- Any outstanding/overdue account that is past due will result in all the family appointments being cancelled and we will not reschedule until the account is brought up to date.
- Any account that is greater than 90 days Past Due will be turned over to our Collection Agency, and due to the administrative charges, you will be subject, in addition, to a collection cost of 40% of the account balance. You may also be responsible for any court costs and reasonable attorney fees. Once your account is sent to collections, you cannot be treated in this office until that balance is $0.**ESTIMATED fees are guaranteed for 45 days. If you are unsure of the fee for service, it is your responsibility to confirm the fee prior to the procedure with the front desk staff.**

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF DANIEL J. FAY, DMD, PA.

Patient Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____