SWIATOWICZ DENTAL ASSOCIATES, P.A.

Family and Aesthetic Dentistry Including Preventive, Restorative, Cosmetic and Reconstructive Treatment

WELCOME TO OUR OFFICE!

Patient Information (please print)

Name _____ Age _____ Birthdate _____-_____-_____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

How do you wish to be addressed _____

Hm #: _____ Wk #: _____ Ext: _____ Cell Phone _____

Whom may we thank for referring you to us? _____

Pharmacy name _____ Pharmacy Phone # _____

Mother/Guardian Information ☐ **Mother** ☐ **Guardian**

Name _____ Birthdate _____-_____-_____ SS #: _____

Employer: _____

Hm #: _____ Wk #: _____ Ext: _____ Cell Phone _____

Father/Guardian Information ☐ **Father** ☐ **Guardian**

Name _____ Birthdate _____-_____-_____ SS #: _____

Employer: _____

Hm #: _____ Wk #: _____ Ext: _____ Cell Phone _____

Responsible Party

Person responsible for account? _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Hm #: _____ Wk #: _____ Ext: _____ SS #: _____

Primary Dental Insurance Information:

Insurance Co Name _____ Insurance Co Phone #: _____

Insurance Co Address _____ City _____ St _____ Zip _____

Group # _____ ID # _____ Max . Annual Benefit _____

Insured's Name: _____ _____ Relationship to patient _____

Insured's Birthdate _____ Insured's SS #: _____-_____-_____ Date employed _____

Insured's Employer _____ City _____ State _____ Zip _____

DO YOU HAVE ADDITONAL INSURANCE: ☐ No ☐ Yes IF YES, COMPLETE THE FOLLOWING

Secondary Dental Insurance Information:

Insurance Co Name _____ Insurance Co Phone #: _____

Insurance Co Address _____ City _____ St _____ Zip _____

Group # _____ ID # _____ Max . Annual Benefit _____

Insured's Name: _____ _____ Relationship to patient _____

Insured's Birthdate _____ Insured's SS #: _____-_____-_____ Date employed _____

Insured's Employer _____ City _____ State _____ Zip _____

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | Today's Date: | Date of Last Visit: | Date of Med. History:

City State Zip: | Email:

Home Phone: | Work Phone: | Cell Phone: | Birth Date: | Social Security No.: | Marital Status:

Primary Dental Guarantor: | Home Phone: | Work Phone: | Cell Phone:

Secondary Dental Guarantor: | Home Phone: | Work Phone: | Cell Phone:

Physician Name: | Physician Phone:

Pharmacy: | Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height:
For Office Use Only BP ☐ Heart Rate: ☐			Weight:

Y	N	Conditions
☐	☐	AIDS/HIV Positive
☐	☐	Abnormal Bleeding
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Back Problems
☐	☐	Cancer- Chemotherapy
☐	☐	Chemical Dependency
☐	☐	Circulatory Problems
☐	☐	Clinical Depression
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Hearing Loss
☐	☐	Heart Attack
☐	☐	Heart Surgery

Y	N	Conditions
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	High Cholesterol/Triglycerides
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Persistent Cough
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tobacco Habit
☐	☐	Tuberculosis
☐	☐	Ulcers

Y	N	Conditions
☐	☐	Lyme Disease
☐	☐	IBS/Stomach Problems
☐	☐	Multiple Sclerosis
☐	☐	Cerebral Palsy
☐	☐	Autism
☐	☐	ADD/ADHD

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

SWIATOWICZ DENTAL ASSOCIATES, P.A.

FINANCIAL RESPONSIBILITY POLICY

For all patients it is necessary to have an easily understood financial responsibility policy whether or not there is dental insurance coverage involved. If there is dental insurance, as a result of the many different and confusing insurance company reimbursement policies it is important for patients to understand how Swiatowicz Dental Associates, P.A. will assist you with your insurance. All patients/responsible parties must sign this form prior to seeing the doctor.

- It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **At each office visit** we need you to show us your insurance card to ensure that your current insurance information is on file.

- As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy. Swiatowicz Dental Associates, P.A. is not responsible for whether or not a service performed is a covered benefit. PLEASE BE AWARE MOST INSURANCE PLANS HAVE A MAXIMUM AMOUNT OF BENEFITS THAT THEY WILL PAY PER PLAN YEAR.

- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.

- If the patient has coverage with a second insurance company, we will submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance. As coordination of benefits is unpredictable, payment from the secondary insurance coverage may be paid directly to the patient.

- Insurance is a patient's benefit designed to assist the patient in their financial obligation to the office of Swiatowicz Dental Associates, P.A. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of *Swiatowicz Dental Associates, P.A.*

- At the time of service, the office will estimate the anticipated insurance payment and will collect the estimated balance due along with any deductible which applies. Swiatowicz Dental Associates, P.A. cannot guarantee any estimated coverage. After the primary insurance payment is received any related contractual adjustment will be applied and the patient will be billed for any difference between the estimated balance due and the actual balance due. If the insurance payment is greater than what was anticipated, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.

- In the event that the patient does not have insurance coverage or the patient's insurance company sends the insurance payment directly to them, CHARGES FOR SERVICES ARE DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE RENDERED, unless a signed financial agreement has been approved.

- For your convenience, we accept cash, check, Visa, Mastercard and Discover. We also, offer a dental payment plan through Care Credit.

- Swiatowicz Dental Associates, P.A. requests 48 business hours' notice to change a scheduled appointment. Although, we realize unforeseen events sometimes require missing an appointment, without the appropriate notification in advance, you may be subject to being charged a missed appointment fee.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I am also responsible any balance due because of insurance claims not paid within 60 days of service. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. Swiatowicz Dental Associates, P.A. reserves the right to charge a monthly billing fee and to use a Collection Agency for the collection of an account and will charge that account any collection fees involved. I have read and understand the above and I agree to be responsible for payment of all services rendered and any billing/collection fees accumulated on my behalf or that of my dependents.

_____

Name of Patient (Parent/Guardian if Minor) or Responsible Party (PLEASE PRINT)

_____ _____

Signature of Patient (Parent/Guardian if Minor) or Responsible Party Date

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____

SWIATOWICZ DENTAL ASSOCIATES, P.A.
Andrew C. Swiatowicz, D.D.S.
1211 Milltown Road
Wilmington, DE 19808
302-239-8230
302-476-8188 (fax)
E-mail: DEtoothDR@gmail.com
www.DEtoothDR.com

Date:

To:

For:

Patient Name(s): _____

Patient(s) Date of Birth: _____

Dear Doctor,

Please forward to our office any x-rays (full mouth series, panoramic, bite-wings, etc.) that you might have for the patient(s) listed above. The patient(s) will continue their active dental care in our office. We would also appreciate any other relevant records or a narrative of any areas of health related concerns.

Thank you in advance for your time and attention to this matter.

For better dental health,

Andrew C. Swiatowicz, D.D.S.

Signature for release of records

_____ _____
Patient (or parent) Date