



Appointment Policy Agreement

Metropolitan Dental Care is dedicated to providing quality care to our patients and is pleased to reserve an appointment time exclusively for you. For your convenience, we will make every attempt to meet the needs of your personal schedule.

We reserve time exclusively for each patient and ask that you make every effort to attend your dental appointment. If you find that you cannot keep your appointment, we require a minimum 2 business day's notification. This allows your reserved time to be made available to other patients in need of treatment. To notify us of any change, please call our office during business hours.

We understand that there are unforeseen circumstances that cause reserved appointments to be missed without 2 business days notice; we certainly want to make provisions for this within our policy. In order to make this provision, as well as to maintain the most efficient schedule for all of our patients, our appointment policy is as follows:

- As a courtesy, our staff attempts to confirm appointments one week before the reserved date and time by method of text and/or email. If we do not receive confirmation, we will call two days before the reserved time. We will call a second time, 24 hours prior, if we have not received confirmation.
- Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.
- Patients who don't show up for their appointment or reschedule without the required 2 business days notice will be reminded of our policy, charged a \$50 missed appointment fee and rescheduled as their providers schedule allows.
- Should the second consecutive appointment be broken without the required 2 business days notice, the patient will be charged a \$50 missed appointment fee and offered same day appointments only. Patients will also be notified when their provider has last minute openings available.
- Should the third consecutive appointment be broken without the required 2 business days notice, the patient will be charged a \$50 missed appointment fee and required to supply up front payment for the rescheduled services. Metropolitan Dental Care will apply the appointment deposit towards services, as long as the rescheduled appointment is honored or rescheduled within the required 2 business days. If a patient has dental insurance, the difference will be credited to the patients account once insurance payment has been received. **Please note: Should the third consecutive appointment be broken without following the above guidelines, the patient agrees to forfeit the full deposit.**

Patient printed name

Patient/Guardian Signature

Date



Financial Policy Agreement

Payment is collected at time of service. To make your payment more convenient for you, we accept cash, personal checks and all major credit cards. In addition, we offer an excellent third-party financing through Wells Fargo. Any portion of an account balance beyond 90 days incurs a service charge of 1.5% per month. Returned checks incur a handling fee of \$30.00.

A WORD ABOUT DENTAL INSURANCE...

If you have dental insurance, please provide proof of benefits and our team will be more than happy to confirm your eligibility and benefits. If you were not issued a card, please be prepared to provide the following information.

- Insurance carrier name, claims mailing address and phone number
- Group/Plan number
- Subscriber name and date of birth
- Subscriber ID Number / SS#

We remind you that your insurance is a contract between you, your employer and the insurance company; not between your insurance company and our practice. We can make no guarantee of any estimated coverage, but we will do our best to see that you receive your maximum benefits. Your bill is ultimately your responsibility should insurance not cover the expected amount due, or if your insurance fails to pay us.

- As a courtesy, we will file your claim and wait for the estimated insurance payment, but it is ultimately your responsibility to see that the claims are paid.
- We will follow up with your insurance company for claims not paid within 30 days, with a phone call.
- If after 60 days the claim is still not paid, we will follow up with insurance again. In addition, we will contact you and ask for your help in getting the claim paid. We will provide you with a copy of the dental claim including all information given to the insurance company. Please retain in your records and reach out to your insurance carrier.
- If after 90 days the claim is not paid by insurance, we will close the claim in our system and the balance due will be requested from you.

Patient printed name _____

Patient/Guardian Signature

Date

Welcome to Metropolitan Dental Care

Personal Information

Date _____
First Name _____ Last Name _____ Middle Initial _____
Preferred Name _____ Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Male _____ Female _____ Nonbinary _____
Minor _____ Single _____ Married _____ Domestic Partner _____ Driver's License State & # _____
Birth Date _____ Social Security # _____
Employer _____ Occupation _____
E-mail Address _____
How do you prefer to be contacted? E-mail _____ Text Message _____ Home # _____ Work # _____ Cell # _____
Who may we thank for referring you to our office? _____
Emergency Contact _____ Phone # _____

Responsible Party

Who is responsible for the account?(If other than yourself) _____
Name _____
Relationship to Patient _____ Birth Date _____ Driver's License # _____
Social Security # _____ E-mail Address _____
Address _____
City, State, Zip _____
Employer _____ Occupation _____
Method of Payment Cash _____ Check _____ Credit Card _____

Primary Dental Insurance Information

Name of Policy Holder _____ Relationship to Patient _____
Insured's Birth Date _____ Insured's Social Security # _____
Group # _____ Insured's ID # _____
Employer _____ Phone Number _____ Occupation _____
Insurance Company _____
Claims/Insurance Company Address _____
City, State, Zip _____

Additional (Secondary) Dental Insurance

Name of Policy Holder _____ Relationship to Patient _____
Insured's Birth Date _____ Insured's Social Security # _____
Group # _____ Insured's ID # _____
Employer _____ Phone Number _____ Occupation _____
Insurance Company _____
Claims/Insurance Company Address _____
City, State, Zip _____

Consent:

I understand that responsibility for payment of dental services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees, and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to the Dentist. I acknowledge that my signature on this document authorizes the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor.

Responsible Party's Signature _____ Date _____

Dental History

Do you have or have you had any of the following?

Jaw/joint disorder
Injury to mouth/face
Tooth Removal
Orthodontic treatment/Braces
Bleeding gums
Periodontal surgery
Sensitivity to hot/cold/sweets/pressure

Nitrous Oxide Gas
Dental problems now _____

Is there anything you wish you could
change about your teeth? _____

Have you ever had an unpleasant dental experience?

Do you need to be pre-medicated with antibiotics before dental procedures (i.e. for congenital heart conditions)? Yes No

Previous Dentist _____ Date of last dental visit _____

Why have you come to the dentist today? _____

How would you describe the condition of your teeth and gums? Good Fair Poor

Are you currently in pain or discomfort with your teeth and gums? Yes No

If yes, please explain: _____

If you could wave a magic wand and change anything you could about the appearance of your smile, what would you like to do?

If you could easily and safely whiten your teeth, would you be interested? Yes No

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? Yes No Floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No Do you grind your teeth? Yes No Do you snore? Yes No

Have you ever been treated for TMJ symptoms? Yes No If yes, please explain: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? Yes No If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you take or have you taken oral or I.V. bisphosphonates or any drugs for osteoporosis? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have or have you had any of the following?

AIDS/HIV positive	Congenital Heart Disorder	Heart Attack/Failure	Mitral Valve Prolapse	Tonsillitis
Alzheimer's Disease	Convulsions	Heart Murmur	Pain in Jaw Joints	Tuberculosis
Anaphylaxis	Cortisone Medicine	Heart Pace Maker	Parathyroid Disease	Tumors or Growths
Anemia	Diabetes	Heart Trouble/Disease	Radiation Treatment	Ulcers
Angina	Drug Addiction	Hemophilia	Recent Weight Loss/Gain	STD's
Arthritis/Gout	Easily Winded	Hepatitis A	Renal Dialysis	Yellow Jaundice
Artificial Heart Valve	Emphysema	Hepatitis B or C	Rheumatic Fever	High Cholesterol
Artificial Joint	Epilepsy/Seizures	Herpes	Rheumatism	Osteoporosis
Asthma	Excessive Bleeding	High Blood Pressure	Scarlet Fever	Eating Disorder
Blood Disease	Excessive Thirst	Hives or Rash	Shingles	Prostate Issues
Blood Transfusion	Fainting Spell/Dizziness	Hypoglycemia	Sickle Cell Disease	HPV
Breathing Problem	Frequent Cough	Irregular Heartbeat	Sinus Trouble	Other not listed _____
Bruise Easily	Frequent Diarrhea	Kidney Problems	Spina Bifida	
Cancer	Frequent Headaches	Leukemia	Stomach/Intestinal Disease	NONE OF THE ABOVE
Chemotherapy	Genital Herpes	Liver Disease	Stroke	Current Height _____
Chest Pains	Glaucoma	Low Blood Pressure	Swelling of Limbs	Current Weight _____
Cold Sores/Fever Blisters	Hay Fever	Lung Disease	Thyroid Disease	(used for prescription dosage)

Physician _____ Phone _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ **DATE** _____

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND 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: _____

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.

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

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES 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:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> Any of the Above |

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

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> 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:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the above (opt out) |
| <input type="checkbox"/> Email | |

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.

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** for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

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



Credit Card on File Agreement

We can securely maintain your credit card information on file with our merchant services. This information will be securely held until your insurance provider has paid their portion of your bill or if payment has not been received from the insurance provider in 90 days. At that time, any balance, which you owe to our office for services that have already been rendered, will be charged to your credit card and a receipt will be sent to you.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays and coinsurances are still due at the time of service.

I authorize Metropolitan Dental Care to charge any outstanding balance on my account, including co-payments and coinsurances to the following credit card:

VISA MASTERCARD AMEX DISCOVER

Name on card: _____

FULL CREDIT CARD #: _____

Expiration date: _____

3 Digit Code (on back of card): _____

Cardholder Signature: _____

Today's Date: _____

If your account balance is over **\$75** your payment will not be processed without prior notification.

I understand that I can cancel this authorization through written notice to Metropolitan Dental Care.

Patient Signature

Date