|  |  |
| --- | --- |
| **7643 JOLLY LANE | BROOKLYN PARK, MN 55428**  **PHONE:** (763) 762-7927  **WEB:** IAUDENTAL.COM **EMAIL:** INFO@IAUDENTAL.COM | **FOR OFFICE USE ONLY**  **VERIFIED: \_\_\_\_\_\_\_\_\_\_ INSURED: Y / N**  **(STATE ) ( PRIVATE REMAINING BAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**  **DOES PT HAVE ANY: HX NO HX**  **LAST PANO / FMX / BW: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **COMP:\_\_\_\_\_\_\_ FMD: \_\_\_\_\_\_\_\_\_ PERIO: \_\_\_\_\_\_\_\_\_\_\_**  **SCANNED: Y / N INITIALS: \_\_\_\_\_\_\_\_\_\_** |

**NEW PATIENT FORM**

**PART ONE - PATIENT INFORMATION**  \***TODAY’S DATE: \_\_\_\_\_ /\_\_\_\_\_ / 20\_\_\_\_\_**

* **[ ] CHECK THIS BOX IF YOU ARE THE PATIENT**
* IF YOU ARE COMPLETING THIS FORM FOR A PATIENT UNDER THE AGE OF 18 YEARS OLD OR A PATIENT WITH SPECIAL NEEDS YOU MUST COMPLETE PART TWO OF THIS NEW PATIENT FORM.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**[ ] MR [ ] MISS / MS. [ ] MRS. [ ] DR.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | \_\_ \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ |

**First Name Middle Initial Last Name SOCIAL SECURITY #**

**GENDER: [ ] MALE [ ] FEMALE DATE OF BIRTH:** \_\_\_\_\_ /\_\_\_\_\_ / \_\_\_\_\_\_  **AGE:** \_\_\_\_\_\_ **EMAIL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CELL:** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **HOME:** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WORK:** ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARITAL STATUS:** SINGLE MARRIED DIVORCED LEGALLY SEPARATED WIDOWED OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* PHYSICAL ADDRESS:**   **\* MAILING ADDRESS (IF DIFFERENT PHYSICAL ADDRESS):**

|  |  |
| --- | --- |
|  |  |
| **HOUSE NUMBER** **STREET NAME**  **APT/SUITE** | **HOUSE NUMBER**  **STREET NAME**  **APT/SUITE** |
| CITY STATE ZIP-CODE | CITY STATE ZIP-CODE |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer / Company Name Your Position Title / Occupation Years / Months with Employer**

**PART TWO – PARENT / LEGAL GUARDIAN INFORMATION**

**RELATIONSHIP TO PATIENT? [ ] PARENT [ ] AUTHORIZED REP TO ACT ON PATIENT’S BEHALF [ ] OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FIRST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I.** \_\_\_\_ **LAST NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EMAIL:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: ( ) \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOUSE NUMBER STREET CITY STATE ZIP**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer / Company Name Your Position Title / Occupation Years / Months with Employer**

**EMERGENCY CONTACT (In case there is an emergency, who should IAU Dental contact?)**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE INFORMATION SECONDARY INSURANCE INFORMATION**

**[ ] PRIVATE INSURANCE [ ] STATE INSURANCE [ ] PRIVATE INSURANCE [ ] STATE INSURANCE**

**Main Subscriber / Policyholder’s:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Main Subscriber / Policyholder’s:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_\_ **SS#: \_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_/ \_\_\_\_\_/ \_\_\_\_\_\_\_ **SS#: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us? If you were referred to us by someone please let us know so we can thank them properly.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7643 JOLLY LANE | BROOKLYN PARK, MN 55428**

\*\*Applies **ONLY** to those who have insurance coverage of **ANY** kind\*\*

**PHONE:** (763) 762-7927

**WEB:** IAUDENTAL.COM **EMAIL:** INFO@IAUDENTAL.COM

**Assignment Of Benefits Agreement**

**Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.**

**It is your responsibility to provide accurate identifying personal information when requested in order for us to confirm that you have dental insurance coverage. If you are insured with more than one insurance plans, it is important that you disclose both with us so that we can file your dental claims properly. Your insurance plans sometimes work together or share your benefits/plan coverage information with one another to coordinate your coverage benefits to determine claim reimbursement amounts. By not disclosing this information to us, your insurance plan will hold all claim payments or deny the claims, until they receive the information that they need from “you” in order to proceed with the claims. If you do not disclose such information to us and your insurance denies your claims for any reason, you will be responsible for the entire unpaid balance for those services.**

* Although we are willing to complete insurance information forms and submit claims on your behalf, we do not accept responsibility for the outcome of the transactions. Completing insurance forms is a courtesy we extend to you in an effort to provide you with the most accurate estimate for treatment/services and to maximize your insurance reimbursement. By having our office process your insurance forms and claims, it is important that you understand that this does not eliminate your financial obligation for your treatment.
* We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs and allows your insurance company to make payment directly to our office.
* We require you to pay the co-payment and the deductible amounts which are the amounts not covered by your insurance company but are required by your insurance to be paid prior to moving forward with particular treatment/services – at the time we provide service to you.
* Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
* **Please note that your insurance quotes in bold that any information provided is not a guarantee of payments or benefit coverage, as coverage is subject to limitations, frequencies, and eligibility for services at the time that the services are rendered to you.** Our office does not guarantee that your insurance company will pay for any or all treatments you receive from our practice, though we perform routine insurance billing procedures and will call your insurance plan to verify your coverage. It is your responsibility to familiarize yourself with your plan’s services/coverage level. If your claims are denied, you will be responsible for paying the full amount at that time. Any questions related to coverage are not our responsibility as we do not have any say in the payments or coverage decisions and you will need to contact your insurance company directly.
* Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I HAVE READ, I UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS PROVIDED ABOVE.**

**I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS, IF ANY, DIRECTLY TO IAU DENTAL – 7643 JOLLY LN, BROOKLYN PARK, MN 55428. I AUTHORIZE AND CONSENT TO KEEP MY SIGNATURE ON FILE AND TO USE MY SIGNATURE WHEN REQUIRED TO FILE MY DENTAL INSURANCE CLAIMS.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Full Name Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Parent/Guardian/Legal Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient/Guardian/Legal Representative**   **Date**

**7643 JOLLY LANE | BROOKLYN PARK, MN 55428**

**PHONE:** (763) 762-7927

**WEB:** IAUDENTAL.COM **EMAIL:** INFO@IAUDENTAL.COM

**AUTHORIZATION & CONSENT OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**IAU Dental is fully compliant with the privacy rules and regulations regarding the use and disclosure of “Protected Health *Information” (PHI) of our patie*nts as outlined under the “HIPAA” (Health Information Portability & Accountability Act 1996).**

**Patient’s Full Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian/Legal Rep’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Parent / Legal Guardian -If patient is a minor or under care of someone other than self)

**I UNDERSTAND:**

* **IAU Dental** will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization form.
* I may revoke this authorization or request a restriction to limit access to my PHI at any time.
* I must complete a new form to request a revocation of this authorization in person.
* Once my “Protected Health Information” (PHI), is released or disclosed by **IAU Dental** to the above recipient(s) it may no longer be protected by federal or state laws under “HIPAA.” Your information may be subject to re-disclosure by the recipient of the information.

**AUTHORIZATION OF PHI DISCLOSURE:**

**I “AUTHORIZE” AND GIVE “CONSENT” TO IAU DENTAL TO USE & DISCLOSE MY “PROTECTED HEALTH INFORMATION” TO THE RECIPIENTS LISTED BELOW. THIS AUTHORIZATION WILL STAY IN EFFECT UNTIL I REQUEST A REVOCATION OF IT.**

**The names of the individual(s) listed below have your authorization/consent to access or obtain information related to your PHI. (Ex: This authorization will allow the individual(s) whose names are on this form to be able to call and schedule your appointments, ask questions regarding your treatments and services, pick up your requested documents and etc.)**

* Name of Person #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of Person #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_

**BY SIGNING THIS AUTHORIZATION FORM:**

I HAVE “READ,” “I UNDERSTAND,” “I ACCEPT,” & “I AGREE” TO THE TERMS & CONDITIONS OF THIS AUTHORIZATION. I HAVE ALSO BEEN GIVEN A COPY OR HAVE BEEN OFFERED A COPY OF THIS AUTHORIZATION TO KEEP FOR MY RECORDS. SHOULD I CHOOSE NOT TO OBTAIN A COPY, I HAVE BEEN INFORMED OF MY RIGHTS AND OF HOW TO REQUEST A COPY AT A LATER TIME.

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR (Parent/Legal Guardian/Legal Representative)**

**. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**

**ACKNOWLEDGEMENT OF THE RECEIPT, ACCEPTANCE, AND AGREEMENT OF IAU DENTAL’S FINANCIAL, TREATMENT, GENERAL OFFICE AND SAFETY POLICY**

I HAVE “READ,” “I UNDERSTAND,” “I ACCEPT,” & “I AGREE” TO THE TERMS & CONDITIONS OF **IAU DENTAL’S**, “FINANCIAL, TREATMENT, GENERAL OFFICE AND SAFETY POLICIES.”

I HAVE ALSO BEEN GIVEN A COPY OR HAVE BEEN OFFERED A COPY OF THE POLICY TO KEEP FOR MY RECORDS. SHOULD I CHOOSE NOT TO OBTAIN A COPY, I HAVE BEEN INFORMED OF MY RIGHTS AND OF HOW TO REQUEST A COPY AT A LATER TIME.

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR (Parent/Legal Guardian/Legal Representative)**

**To determine if you are a “Legal Guardian/Legal Representative” for the patient:**

* **If Patient is a minor child defined under Minnesota State Laws**
* **If Patient is disabled, receiving social services and person completing this form is the legal representative or appointed representative to act on patient’s behalf**

**7643 JOLLY LANE | BROOKLYN PARK, MN 55428**

**PHONE:** (763) 762-7927

**WEB:** IAUDENTAL.COM **EMAIL:** INFO@IAUDENTAL.COM

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.**

**Patient’s Full Name (Print)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First, Middle, Last) (MM / DD / YYYY)

**Print Full Name (Parent/Guardian/Personal Rep):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(If patient is a minor or under care of someone other than self)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **have received a copy of “IAU Dental’s Notice of Privacy Practices.”**

(**Patient / Parent / Legal Guardian** -If patient is a minor or under care of someone other than self)

**Signature Box:**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Legal Guardian/Legal Representative’s 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:

Reason for Refusal:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other: (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IAU Dental Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_