306 S. 4th Street Ste. 100
Seward, NE 68434
Ph. (402) 643-2931 Fax (402)643-4258
Email: office@sewarddentalclinic.com

Patient Information

First Name:_____________________ Middle:___________ Last:___________________________

Address:________________________________ City:______________ State:_____ Zip:________

Home Phone:__________________ Cell Phone:_________________ Email:_________________

Birthdate:______________ Marital Status: (please circle one) Single Married Divorced Widowed

Employer:_____________________________ Position:__________ Work Phone:______________

Referred by:___________________________ Emergency Contact:___________________________

Responsible Party Information

Name of Responsible Party (if different than patient):____

Relationship to patient:___________________ Contact Number:_____________________________

Address:________________________________ City:______________ State:_____ Zip:________

Employer:_____________________________ Position:__________ Work Phone:______________

Dental Insurance:

Name of Insured:________________________________ Relationship to Patient:_______________

Birthdate:___________ ***Social Security Number**:_____________Employer:_______________

Insurance Carrier:_______________________________ Phone:_____________________________

Address:________________________________ City:______________ State:_____ Zip:________

Member ID #:____________________________

Secondary Insurance Carrier (if applicable):_____________________________ Phone:___________

Address:________________________________ City:______________ State:_____ Zip:________

Name of Insured:________________________________ Relationship to Patient:_______________

Birthdate:___________ Social Security Number:_______________ Employer:_________________

Member ID #:____________________________

Patient or Guardian Signature:____

Seward Dental Clinic Financial Policy

We, at Seward Dental Clinic, are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. In order to assist you with your health care investment, we are providing the following payment options.

PAYMENT:

Payment is due at the time of service. We do accept cash, personal checks with current date, major credit cards, debit cards and third party financing through Care Credit.

INSURANCE:

As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are estimates only they are not a guarantee of payment. The patient is ultimately responsible for all charges incurred. Our first and only priority is our patients and the quality of care. The negotiation of benefits is between you, your employer and insurance company.

RETURNED CHECKS:

All returned checks are subject to a $30.00 returned check fee. Any unpaid returned checks will be forwarded to the District Attorney for collection.

DELINQUENT ACCOUNTS:

Accounts over 90 days past due will be referred out for collection and the patient is responsible for any fees associated with that process, unless previous arrangements have been made.

CANCELLATION POLICY:

It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities. We do require 24 hours notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. We are then also able to offer all of our patients' the same exceptional standard of care.

FINANCING OPTIONS:

Ask our team how we can help you with your financial needs. We offer some 0% interest plans through Care Credit. We will be happy to help you with this. Financing your treatment will allow you to begin your treatment immediately and spread the cost over a period of time.

I have read the above and understand and agree to these terms. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of benefits to be directly to SEWARD DENTAL CLINIC P.C.

____ ___________________________

Patient/Responsible Party Date

HIPAA Acknowledgment Form

I give permission to discuss my account and dental records with my immediate family, as in my spouse, parents, or children as designated by responsibility for scheduling or payment of my account.

I understand that in compliance with HIPAA law, I may make specific amendments to what information is released and to whom, and may revoke all or part of this agreement in writing at any time.

I have been informed of the HIPAA Omnibus Privacy Act and received a copy (if requested). I have also been informed that I will be notified by this office if my personal health information is subject to a breach in privacy.

______________________________ _________________________

Printed Name

______________________________ _________________________

Patient Signature Date

______________________________ _________________________

Parent or Guardian signature (if minor) Date

Seward Dental Clinic Medical History

Patient Name: Birth Date: Date Created:

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, c

Question			
Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation in the last 5 years?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Do you use tobacco?	Yes	No	

Women: Are you...

- [ ] Pregnant/Trying to get pregnant?
- [ ] Nursing?
- [ ] Taking oral contraceptives?

Are you allergic to any of the following?

- [ ] Aspirin
- [ ] Penicillin
- [ ] Codeine
- [ ] Acrylic
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics

Other medication allergies? Yes No If yes

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

Condition			Condition			Condition			Condition		
AIDS/HIV Positive	Yes	No	Congenital Heart Disease	Yes	No	Hepatitis A	Yes	No	Alzheimer's Disease	Yes	No
Cold Sores	Yes	No	Hepatitis B or C	Yes	No	Angina	Yes	No	Chest Pain	Yes	No
Hemophilia	Yes	No	Arthritis/Gout	Yes	No	Diabetes	Yes	No	Heart Pacemaker	Yes	No
Artificial Heart Valve	Yes	No	Drug Addiction	Yes	No	High Blood Pressure	Yes	No	Asthma	Yes	No
Emphysema	Yes	No	High Cholesterol	Yes	No	Anemia	Yes	No	Epilepsy or Seizures	Yes	No
Heart Murmur	Yes	No	Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Kidney Disease	Yes	No
Blood Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Liver Disease	Yes	No	Blood Transfusion	Yes	No
Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Bruise Easily	Yes	No	Glaucoma	Yes	No
Leukemia	Yes	No	Chemotherapy	Yes	No	Hypoglycemia	Yes	No	Mitral Valve Prolapse	Yes	No
Cancer	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Cortisone Medicine	Yes	No
Heart Trouble/Disease	Yes	No	PreMedication	Yes	No	Pain in Joints	Yes	No	Radiation Treatments	Yes	No
Rheumatic Fever	Yes	No	Recent Weight Loss	Yes	No	Sinus Trouble	Yes	No	Stroke	Yes	No
Scarlet Fever	Yes	No	Thyroid Disease	Yes	No	Tonsilitis	Yes	No	Tuberculosis	Yes	No
Ulcers	Yes	No	Venereal Disease	Yes	No						

Question			
Have you ever had any serious illness not listed above?	Yes	No	If yes
If you have an artificial joint, please indicate which one:	Yes	No	If yes

Comments:

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:

X

Date:___________