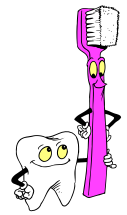




# Timothy L. Nibert, D.D.S.

## Patient Acquaintance Form Patient Information



**Welcome!**

### Information

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Beeper or Cellular Phone \_\_\_\_\_ Sex(M/F) \_\_\_\_\_

Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ Social Security \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Billing Address \_\_\_\_\_ Relation to patient \_\_\_\_\_

### Insurance Information

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Policy or Group # \_\_\_\_\_ Do you have secondary dental insurance? \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Policy or Group # \_\_\_\_\_ SS# Policy Holder \_\_\_\_\_

### Dental History

Reasons for today's visit \_\_\_\_\_

Former Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental x-ray \_\_\_\_\_

Are you happy with your smile? \_\_\_\_\_ If No, Explain \_\_\_\_\_

### Personal

When and where is the best time to reach you? \_\_\_\_\_

Whom do we thank for referring you? \_\_\_\_\_

Date \_\_\_\_\_ Responsible Party Signature \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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. Thank you for answering the following questions.

- 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: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  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 If yes, please explain: \_\_\_\_\_

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No	

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_

**TIMOTHY L. NIBERT, D.D.S.**  
Family and Cosmetic Dentistry



**OFFICE POLICIES**

***Payment for services is ultimately the responsibility of the patient/responsible party. Your dental plan is designed to share in your dental care costs. It may not cover the total cost of your bill.***

**Patients with Insurance:**

Patients with insurance are required to pay their deductible at the time services are rendered. We will make our best effort to properly calculate your copay. If we overestimate your charges, the excess will either be credited to your account or refunded to you by check. If we underestimate your charges, the amount will be billed to you. As a courtesy we will process your insurance claim.

**NOTE: *If a particular service is not covered fully, you will be responsible for the remainder of the fee. If a particular is not covered at all, you will be responsible for the full fee. For portions not covered by insurance, you may choose from the options below.***

***If a patient does not have payment, we will not be able to treat them that day.***

**Portions Not Covered by Insurance:**

Payment in full is expected at the time service is rendered. The following options are available for larger procedures exceeding \$300:

1. CARE CREDIT: Interest free plans are available to those who qualify. Several low-interest for plans are available for extensive treatment plans. Approval is by phone with no paperwork to fill out.
2. Cash, check, credit cards accepted ( MC, VISA, DISCOVER ).

**Cancellation Policy**

The appointment made is reserved especially for you. We require a minimum of 24 hours for cancelled appointments. There will be a \$25 charge for missed appointments. If you miss an appointment that is an hour or more in length, you will be required to make a deposit of one-third of the total cost of the visit for future appointments of that length. Patients who repeatedly cancel appointments without the necessary 24 hour notice or are labeled a no-show will be asked to seek care elsewhere.

**Policy on Returned Checks:**

A fee of \$25 will be assessed for any checks returned from the bank due to insufficient funds.

I have read the above financial and cancellation policies and agree to abide by them. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE.**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

A COPY OF THIS AGREEMENT WILL BE PROVIDED UPON REQUEST

**PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients.** We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of the dental treatment, we at no time guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance, once again, we are filing the claims as a courtesy to you.

### **NO INSURANCE PAYS 100% OF ALL PROCEDURES**

Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

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### **Fact 2 - BENEFITS ARE NOT DETERMINED BY OUR OFFICE**

You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit.

**Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low.** In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

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### **Fact 3 - DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED**

When estimating dental benefits, deductibles and percentages must be considered. To illustrate, assume the fee for service is \$150.00. Assuming that the insurance company allows \$150.00 as its usual and customary (UCR) fee, we can figure out what benefits will be paid. Assuming a \$50 deductible is applicable, then \$50 must be subtracted, leaving a balance of \$100. Assuming that insurance pays such service at 80%, then 80% of \$100 would be \$80. Thus, out of a \$150 fee, insurance would pay \$80 and your co-pay for that service would be \$70. Of course, if the UCR is less than the \$150 or if your plan pays less than 80% for such service, then the insurance benefits could be significantly less.

**SINCE EACH INSURANCE PLAN DIFFERS, IT IS VERY IMPORTANT THAT YOU KEEP US INFORMED OF ANY INSURANCE CHANGES. IF YOU WAIT UNTIL THE TIME OF THE APPOINTMENT, WE MAY NOT BE ABLE TO REACH THE INSURANCE COMPANY TO VERIFY BENEFITS AND WE WILL HAVE TO COLLECT PAYMENT AS IF THE NEW INSURANCE WAS NOT IN EFFECT.**

We reserve the right at any time due to unsatisfactory payment by you or your insurance company or unreliable credit card authorizations to no longer file insurance as a courtesy to you. Of course, if this decision is made, we will immediately inform you of this fact in advance of treatment.