WELCOME TO DR. JEFFREY FINK'S OFFICE

"HEALTHY TEETH & GUMS FOR A LIFETIME"

PATIENT INFORMATION

FIRST NAME _____ M.I. _____ LASTNAME _____ NICKNAME_____

STREET_____CITY_____STATE_____ZIP_____

EMPLOYER_____ SOCIAL SECURITY #_____

BIRTHDATE_____ SEX (PLEASE CIRCLE) MALE FEMALE

MARITAL STATUS (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED

PHONE: HOME (_____)_____ WHAT IS THE BEST CONTACT #?_____
WORK (_____)_____ MAY WE CONTACT YOU AT WORK?_____
CELL (_____)_____ EMAIL _____

IF COLLEGE STUDENT (PLEASE CIRCLE) FT/PT NAME OF SCHOOL_____ STATE_____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME_____PHONE_____

RELATIONSHIP TO PATIENT_____ADDITIONAL PHONE_____

PRIMARY DENTAL INSURANCE COMPANY

SUBSCRIBER NAME_____SOCIAL SECURITY #_____DOB_____

EMPLOYER_____INSURANCE COMPANY_____GROUP #_____

INSURANCE PHONE#_____I.D. #_____RELATION TO PATIENT_____

IF PATIENT IS A MINOR (UNDER AGE 18)

RESPONSIBLE PARTY_____RELATION TO PATIENT_____

STREET_____CITY_____STATE_____ZIP_____

PHONE #_____SOCIAL SECURITY #_____DOB_____

I hereby authorize that all the information on this page is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes.

Signature of Patient, Parent or Guardian_____

Date_____

Jeffrey A. Fink D.D.S. Office Policies

Insurance: We file to the insurance company as a courtesy to our patients, but we cannot accept the responsibility for collecting insurance payments or for negotiating a disputed claim. Insurance is an agreement between you the subscriber and the insurance company. Insurance policies generally only cover a portion of the total treatment cost. This is due to coinsurance, as well as "usual, customary and reasonable fees" established by the insurance company. We will ESTIMATE your patient portion and deductible that will be due at the time services are rendered. You can either expect an overpayment refund or a bill for the uncovered portion of the insurance payment after our office has received it, since it is not possible to predict the exact amount of the insurance payment prior to initiation of treatment. It will be your responsibility to pay any balance not paid by your insurance company within 60 days.
You will be responsible for a collection fee if your account is sent to collections.
Please initial that you have read and understand this policy_____

Financial Agreement: Unless prior arrangements have been made, we ask that payment be made in full at the first visit. We accept Visa, MasterCard, Discover, and American Express, as well as Cash or Check. As a service to our patients, we also offer CareCredit to those who qualify. This plan provides you with different payment options, including interest free options. A charge of $25.00 will be added to your account for any returned check.
Please initial that you have read and understand this policy_____

Appointments: In order to provide quality dental care in an efficient manner, we ask that you give us at least a 24 business hour notice of a cancellation or to reschedule your appointment. A deposit of $50.00 may be required to reschedule appointments that have been broken or excessively cancelled. **Cancellations with less than 24 business hour notice are subject to a $25.00 charge to one's account.** We will make every effort to see you at your appointed time. If you are running late for your appointment, we may have to reschedule due to time constraints and other scheduled patients.
Please initial that you are aware of our $25.00 Cancellation Policy_____

We are happy you have chosen us to provide you and your family with excellent dental care. If you have any questions regarding any of our office policies, please do not hesitate to ask one of our staff members. It is our sincere goal to give our patients a high quality and pleasant dental experience.

Signature of Patient, Parent or Guardian: _____

Date: _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Dr. Fink and Staff is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

Jeffrey A. Fink, D.D.S., PA
970 Branchview Drive NE Suite #110
Concord, NC 28025

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name: _____

I have read or received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: _____
- ❑ Other:_____ _____

Prepared By _____

Signature _____

Date _____