midtownsmiles

(918) 749-1639 | 3150 E 41st Street, Ste. 131, Tulsa, OK 74105

New Patient Information

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ SSN:_____

☐ Male ☐ Female

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Employer/School: _____ Occupation: _____

In case of an emergency, who should be notified? _____ Phone Number: _____

How did you hear about Midtown Smiles?

☐ Facebook ☐ Google ☐ Received something in the mail ☐ Other? Please tell us! _____

☐ Referred by a friend/existing patient

Who may we thank for referring you? _____

Primary Dental Insurance Information

Dental Insurance: ☐Yes ☐ No

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security Number: _____ Insurance Company: _____

Policy Group Number: _____ Policy Holder ID Number: _____

Provider Services Phone Number from back of card: _____

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Secondary Dental Insurance Information

Is the patient covered by an additional dental insurance policy: ☐Yes ☐ No

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security Number: _____ Insurance Company: _____

Policy Group Number: _____ Policy Holder ID Number: _____

Provider Services Phone Number from back of card: _____

Release of Protected Health Information and Assignment of Dental Insurance Benefits

I authorize Dr. Christian Shaun Mirabal, Dr. Rebecca Hughes, and Midtown Smiles to disclose my and/or my dependent(s) protected health information to the above-named dental insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services according to our Notice of Privacy Practices. I assign all payments by my dental insurance company for dental services rendered directly to Dr. Christian Shaun Mirabal, Dr. Rebecca Hughes, and Midtown Smiles. I authorize the use of my signature on all dental insurance submissions. I understand that I am financially responsible for all charges incurred for dental services received regardless if they are a covered service by my dental insurance.

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA POLICIES AND PROCEDURES

You may refuse to sign this acknowledgement

I have received and reviewed a copy of Midtown Smile's privacy, security and breach notification policies and procedures. I understand that I should ask Midtown Smile's Privacy Official if I have any questions about these policies and procedures.

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | 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:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

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Authorization to Release Protected Health Information

Patient's Name: _____ Patient's Date of Birth: _____

I hereby authorize the use and disclosure of the protected patient information to anyone listed below. I understand that I may revoke this Authorization at any time by notifying this office in writing. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. I understand that my health care provider cannot condition treatment on whether or not I sign this Authorization. This Authorization will remain in effect until terminated by me, in writing, or the above-named patient turns 18 years of age, or is no longer a patient of the practice.

Name of person: _____ Relationship to patient: _____

Name of person: _____ Relationship to patient: _____

Name of person: _____ Relationship to patient: _____

Name of person: _____ Relationship to patient: _____

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

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Midtown Smiles Financial Policy

PLEASE BE SURE TO READ CAREFULLY

General Financial Policy

- Dr. Hughes, Dr. Mirabal, and their team are committed to providing you with the best dental care and experience possible.
- Our goal is to maximize your financial resources to improve and/or maintain your dental health, and if you have dental insurance, we want to help you maximize your allowable benefits.
- Dentistry is a business, and excellent care cannot continue be given to patients if there is not solid understanding and agreement between a patient and their dental health provider that payment is expected **BEFORE** services are rendered, unless payment arrangements have been approved.
- When we file your dental insurance benefits as a courtesy to you, payment is expected **BEFORE** services are rendered, unless payment arrangements have been approved.
- Accepted forms of payment in our office is Cash, Check, Visa, MasterCard, or Care Credit
- The reason Midtown Smiles has a policy of payment **BEFORE** services are rendered, is because the last thing you want to do as a patient after a dental appointment is pay. If payment is taken care of before the appointment, then the focus can just be on having the best dental experience possible.

Dental Insurance Financial Policy

- Your dental insurance is a contract between you, your employer, and your dental insurance company. We are not party to that contract
- Our services and fees generally considered fall within the usual and customary range, and should be covered at the maximum allowance determined by your insurance company.
- However, not all services that can be received in our office are a covered benefit in all dental insurance contracts
- Issues with benefits, fees, maximums, and covered services are to be taken up with your dental insurance company by you, the patient. We will be happy to assist you, but it is ultimately is your responsibility since you are who the dental insurance company has the contract with.
- All co-pays, deductibles, and/or previous balances are due **BEFORE** services are rendered.
- If we do not hear from your dental insurance about a dental claim that has been submitted in 30 days, you will personally be billed for the remaining balance not covered by insurance. If/when your benefits are paid, we will reconcile your account.

Cancellation/No-show Policy

- We understand that life happens.
- Please note our office is not open on Friday and cancellation requests must be received by Thursday to be considered 48 hours notice
- ***After 2 cancellations with less than 48 hours notice and/or no-shows, you will be required to place a non-refundable 20% deposit to reserve an appointment to be seen at Midtown Smiles.***

Delinquent Account Policy

- If your account is overdue for more than 90 days, your account will be released to a collection agency.

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative

Relationship to Patient

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_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date