Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date:_____ Social Security #:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Phone (Home): _____(Work): _____ ____ Cell Phone: _____E-Mail_____

Responsible Party Information

The following is for the person responsible for payment

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ Social Security #:

Address:
Street Apartment #

City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone #:

Insurance Information

Primary

Name of Insured: _____ Birth Date: _____
Last First MI

ID #: _____ Insured's Address:
Street City State Zip Code

Insured's Employer Name:

Address:
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ Group #:

Insurance Plan Name and Address:

Secondary

Name of Insured: _____ Birth Date: _____
Last First MI

ID #: _____ Insured's Address:
Street City State Zip Code

Insured's Employer Name:

Address:
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ Group #:

Insurance Plan Name and Address:

Authorization for Signature on File

I, _____ hereby authorize the office of Dr. Macarena Planken DDS PC, to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with_____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dental practice has a contractual agreement with my plan prohibiting all or apportion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim. A photocopy of this document may act as an original.

_____ _____
Signature of Insured Date

_____ _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Use of recreational drugs

OTHER:

- ☐ _____
- ☐ _____

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

· Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

· Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

· Name of Physician: _____ Phone: _____

· Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Update:
Have you had any changes in your health in the last six months? _____
If yes, please explain: _____
Are you taking any medications? _____
If yes, please list: _____

Signature: _____ Date: _____

Update:
Have you had any changes in your health in the last six months? _____
If yes, please explain: _____
Are you taking any medications? _____
If yes, please list: _____

Signature: _____ Date: _____

Update:

Have you had any changes in your health in the last six months? _____
If yes, please explain: _____
Are you taking any medications? _____
If yes, please list: _____

Signature: _____ Date: _____

Macarena Planken DDS
& Associates
we love to see you smile

CONSENT FOR USE AND DISCLSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT:

Name: _____

Address: _____

Telephone #:_____E-mail: _____

Social Security #:_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice Provides a Description of our treatment, Payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, Including any revisions of our Notice, at any time by contacting:
Macarena Planken DDS
Attention: Office Manager
3401 Merrick Road
Wantagh, NY 11793
Phone: (516) 679-9444 Fax: (516) 679-0855
E-mail: Contactus@plankendds.com

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature
I, _____, have had fully opportunity to read and consider the contents of this Consent form and your

Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure to my protected heath information to carry our treatment, payment activities and health care operations.

Signature:_____Date:_____

If this consent is signed by a personal representative on behalf of the patient (i.e. parent or guardian), complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Macarena Planken DDS
& Associates
we love to see you smile

Financial Agreement Policy

We, the staff of ***Macarena Planken DDS, PC*** thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. we are committed to providing you with the highest level if care and to building a successful provider-patient relationship with you and your family. Our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions for concerns regarding our fees, policies, or responsibilities please feel to contact **Andrea Battaglia our office manager at 516-679-9444.**

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate with a plan we are not a provider for, payment for services will be do at the time service is render unless payment arrangements has been made and approved by our office manager in advance.

For your convenience we accept Cash, in-state personal checks, money orders, American Express, Visa, MasterCard, Discover and Care Credit. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Interest

Interest of 2% per month (24% per annum) will incur if a balance remains unpaid after 60 days.

Insurance

Please remember that your insurance policy is an agreement between you and your insurance company, not our office and your insurance company. We try to estimate our patients portion for each procedure but ultimately your insurance company has the final say on it. Please understand that if your insurance benefits result in less coverage than anticipated, you are still responsible for the balance.

We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefits under your policy. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, photo identification and to notify our office of any information changes when they occur. It is the patient's responsibility to know if our office is a participating or non-participating with their insurance plan. Failure to provide accurate information will result in patient having to pay for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, patient portions and deductible, as outlined by your insurance carrier. Even a preauthorization of services does not guarantee payment from your insurance carrier.

Please be aware that if our office does not participate with your plan and we are consider an out of network provider we will still as a courtesy , bill your insurance company. You will be responsible to paying us for the services at the time the procedures is render and your insurance will then forward any payment they deem appropriate to you. Please be aware that there may be a difference in price between our office prices and what your carrier is willing to pay for those services. If we are not contracted with your carrier we will not negotiate a reduced fees with your carrier and our office will not follow up with insurance claims sent to them.

Missed Appointments

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance a missed appointment fee of **$65.00** will apply.

I have read and understand the above financial policy. I agree to assign insurance benefits to ***MACARENA PLANKEN DDS, PC*** whenever applicable. I also agree, in addition to the amount owed and I will also be responsible for the fee charged by the collection agency for cost of collections if such action becomes necessary.

Signature of Insured or Authorized Representative _____
Date: _____

3401 Merrick Rd. Wantagh, New York 11793
Tel: 516-679-9444 Fax: 516-679-0855
www.plankendds.com Contactus@plankendds.com