HAGLER-SCIARRILLA FAMILY DENTISTRY

TIM HAGLER, D.D.S.
RONALD SCIARRILLA, D.D.S.

WELCOME TO OUR OFFICE!

We would like to thank you for choosing our office for your dental needs. As often happens in offices, the patient usually has questions regarding office polices for finances, missed appointments, etc. and we would like to take this opportunity to explain them to you so there will be no misunderstandings later.

FINANCIAL INFORMATION:
Payment is due when services are rendered. Our financial manager will be happy to discuss our fees with you PRIOR to seeing the doctor. We want our patients to understand our fees and feel confident that they are getting the best dental care available for their dollar. You will be provided with a detailed itemization of charges at the time of payment for this visit. We suggest that you keep this record of your visit which will also indicate that your account is paid in full. At this time, you will be given an appointment card as a reminder of any future appointments if needed. Should you feel at this time that payment of your account in full will not be possible, we request that you speak to our office staff AT THIS TIME. Your financial arrangements will be kept confidential with our financial manager.

This office will file your insurance as a courtesy and will provide you with a treatment plan and estimated payments to be made at the time of each appointment. The patient will be responsible for all charges not covered by insurance and it is the patient's responsibility to know their insurance benefits.

Payment in full is expected if you do not have copies of your insurance information or it cannot be verified.

ACCEPTED FORMS OF PAYMENT: Cash, Check, Charge
We now accept Visa, Mastercard, Discover, American Express and Care Credit. We can take payment over the phone by credit or debit card for your convenience.

DIVORCE:
Remember, divorce is a civil action between husband and wife, not this office. Your bill is still payable and due. Federal and state laws supersede divorce actions. Divorce does not cancel financial responsibility for your minor children YOU bring in for treatment.

NO SHOWING AN APPOINTMENT:
We realize that sometimes "things" come up and you are unable to keep an appointment. PLEASE CALL AT LEAST 24 HOURS IF AT ALL POSSIBLE, TO CANCEL AN APPOINTMENT. We reserve the right to discharge you as a patient if you no show two or more times.

MINOR CHILDREN:
Minor children 17 years and younger. When you send your son or daughter to see us without their natural/adoptive parents being present we MUST HAVE A SIGNED LETTER BY YOU stating that we have your permission to treat them without you being present even if we see them on a regular basis. The stepparent, brother, sister, grandparent, etc. is not considered "legally" responsible.

Please allow the receptionist to copy your insurance card and drivers license for proper identification. We would like to take this opportunity once more to thank you for choosing us. Please let us know if you have any questions or concerns.

_____ _____
Signature Date

(We will be happy to provide you a copy of this if you so desire)

HAGLER-SCIARRILLA FAMILY DENTISTRY

PATIENT INFORATION (*CONFIDENTIAL)*

DATE:_____

NAME:_____ SEX: MALE / FEMALE
FIRST MI LAST

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

E-MAIL:_____ CELL PHONE:_____ HOME PHONE:_____

SS#/SIN:_____ BIRTHDAY:_____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

SPOUSE OR PARENT'S/GUARDIAN'S NAME:_____ CONTACT PHONE:_____

PATIENT'S OR PARENT'S/GUARDIAN'S NAME:_____ WORK PHONE:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:_____ PHONE:_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ HOME PHONE: _____

DRIVER'S LICENSE #: _____ BIRTHDATE: _____ SS#/SIN: _____

EMPLOYER: _____ WORK PHONE: _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO CELL PHONE: _____

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE:_____ SS#/SIN: _____ DATE EMPLOYED: _____

NAME OF EMPLOYER: _____ UNION OR LOCAL #:_____ WORK PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE CO: _____ TEL #_____ GRP: _____ POLICY #_____

INS CO ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

We are more than happy to help you by submitting your insurance claim as a courtesy for you without charge. We make every effort to submit your claim the same day. Insurance coverage enables you to get financial help in paying for a portion of your dental fees. **YOU ARE RESPONSIBLE FOR THE PORTION THEY DO NOT COVER**. Payment is due when service is rendered. Every insurance company has a yearly deductible. You need to know what your deductible is, and you must pay that amount before your insurance company will begin to pay benefits. Our office will file primary insurance only. A secondary policy is your responsibility. Our agreement is with you, not with the insurance company. **IF YOUR INSURANCE COMPANY HAS NOT PROCESSED YOUR CLAIM IN 90 DAYS YOU ARE RESPONSIBLE FOR THE BALANCE.**

If there is any additional treatment necessary, we will discuss it with you before proceeding. I understand that I am financially responsible for the dental fees, with or without insurance payment.

I hereby authorize any insurance company to release all information with bearing on the benefits payable under this or any other plan providing benefits or services. I authorize payment of benefits directly to the provider of service.

SIGNATURE: _____ DATE: _____

Patient Consent Form

TIM HAGLER, D.D.S.
RONALD SCIARRILLA, D.D.S.
1273 N. Main
Vidor, Texas 77662
(409) 769-3887

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign, in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Patient Signature: _____

Relationship to Patient: _____ Date: _____

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HEALTH HISTORY

PATIENT'S NAME: _____ DOB: _____

Please discuss the following conditions, per your current & past health history; some MAY require a pre-medication (*) or physician approval prior to dental treatment.

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

AIDS/HIV
ALZHEIMER'S
ANEMIA
ANGINA/CHEST PAIN
ARTHRITIS/GOUT
ARTIFICIAL HEART VALVE &/OR STENT*
ARTIFICIAL JOINT
ASTHMA
BACK/NECK PAIN
BLOODY SPUTUM
BREATHING PROBLEMS
BRUISE EASILY
CANCER
CHEMOTHERAPY*
CHEMICAL DEPENDENCY
COLD SORES/FEVER BLISTERS
CONGENITAL HEART DISORDER
CORTISONE MEDICINE /OTHER STEROIDS
DEPRESSION
DIABETES
EATING DISORDERS
EPILEPSY SEIZURES
EMPHYSEMA
EXCESSIVE BLEEDING
EXCESSIVE THIRST
FAINTING/DIZZY SPELLS
FREQUENT COUGH
FREQUENT DIARRHEA
GI/COLON ISSUES
GLAUCOMA
HAY FEVER
HEART SURGERY*
HEART MURMUR*
HEART PACEMAKER
HEART TROUBLE/DISEASE
HEMOPHILIA
HEPATITIS A-INFECTIOUS
HEPATITIS B OR C
HERPES
HIGH BLOOD PRESSURE
HISTORY OF BLOOD TRANSFUSION
HISTORY OF HEART ATTACK
HYPOGLYCEMIA
IRREGULAR HEARTBEAT
JAW PAIN (TMJ)
JOINT PAIN
KIDNEY DIALYSIS PROBLEMS
LATEX ALLERGY
LEUKEMIA*
LIVER DISEASE
LOW BLOOD PRESSURE
MITRAL VALVE PROLAPSE*
NERVOUSNESS
NIGHT SWEATS
ON ANTIBIOTIC PRE-MED
ON BLOOD THINNERS
PSYCHIATRIC CARE
RADIATION THERAPY*
RECENT WEIGHTLOSS
RHEUMATISM
RHEUMATIC FEVER*
SCARLET FEVER*
SHORTNESS OF BREATH
SICKLE CELL DISEASE
SINUS TROUBLES
SLEEP APNEA
STROKE
SWELLING OF LIMBS(ANKLES)
TAKE FOSAMAX/BONIVA
THYROID TROUBLE
TONSILLITIS
TUBERCULOSIS
ULCERS
UNEXPLAINED FEVER
USE TOBACCO
VENEREAL DISEASE

MAKE A CHECK MARK ONLY IF THE ANSWER IS YES:
Have you been a patient in the hospital during the past 2 years? YES _____
If yes, what for: _____
Have you been under the care of a medical doctor during the past 2 years? YES _____
Physician's Name: _____ Phone Number:_____
ARE YOU CURRENTLY TAKING ANY PRESCRIPTION DRUGS OR OVER THE COUNTER MEDICATIONS? YES _____
Please List: _____
DRUG ALLERGIES: Do you have any known drug allergies. Have you become ill or shown allergy to or been told not to take any of the following- Please circle: Penicillin, Keflex, Sulfa Drugs (or other antibiotics), Codeine, Novocain, or other dental anesthetic? Please list:
_____
Do you have any other allergies? YES _____ Please List: _____
Do you have any disease, condition or problem not listed that we should know about? YES _____Please List: _____

WOMEN: Are you pregnant? NO _____ YES _____ Due Date: _____
Are you taking birth control medication? NO _____ YES _____

INFORMED CONSENT
I verify that the answers to the health questions are correct. Since a change of medical conditions or medication can affect dental treatment, I understand the importance of and agree to notify the doctor of any changes at any subsequent appointment. I give my consent for the dental treatment the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I also agree to the use of a local anesthesia, as needed. This office has + pressure breathing apparatus, incl. O2 and current emergency drugs up to date. Staff current in basic cardiac life support.

Patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibility as connected with such treatment.

Patient/Parent Signature: _____ Date: _____