MODERN DENTAL CONCEPTS

New Patient Packet

4817 Mahoning Avenue NW, Warren, Ohio 44483 · (330) 847-0676 · moderndentalconcepts.com

Welcome to Modern Dental Concepts! Please complete this registration packet before your first visit. Your information is kept confidential in accordance with HIPAA and applicable laws. If a question does not apply to you, leave it blank or write "N/A."

1. Patient Information

Patient Name:		Preferred Name:	
Date of Birth:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single ☐ Minor	
Social Security #:	Email:		
Address:			
City:		State:	ZIP:
Home Phone:	Cell Phone:	Employer:	
Have you ever served in the military? ☐ Yes ☐ No		Branch:	
How did you hear about us?			
Emergency Contact (name & relationship):		Phone:	

2. Parent / Guardian Information (if patient is a minor)

Name:		Relationship to Patient:	
Date of Birth:	Social Security #:	Phone:	
Address:			
City:		State:	ZIP:

3. Dental Insurance

Primary Insurance

Policyholder's Name:	Date of Birth:	SS#:
Insurance Company:	ID #:	Group #:
Employer:		

Secondary Insurance

Policyholder's Name:	Date of Birth:	SS#:
Insurance Company:	ID #:	Group #:
Employer:		

4. HIPAA Release

Patient Name:

Appointment reminders — may we contact you by: Voicemail / answering machine? ☐ Yes ☐ No Email? ☐ Yes ☐ No Text? ☐ Yes ☐ No

Information about my treatment at Modern Dental Concepts can be given to the following people (do not include physicians):

Name:	Name:
Relationship:	Relationship:
Phone Number:	Phone Number:

Signature:	Date:
(If minor) Parent / Guardian Name:	

5. Acknowledgment of Receipt of Notice of Privacy Policy

The office Privacy Policy is posted in the lobby for your viewing convenience. If you would like this notice printed, please inform the front desk and a copy will be given to you.

I have viewed / received a copy of this office's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, Modern Dental Concepts to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose.

Signature:	Date:
(If minor) Parent / Guardian Name:	

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
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify): _____
Staff initials: _____

6. Financial Policy

Thank you for choosing Modern Dental Concepts. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible, by offering several payment options.

Payment Options: Acceptable forms of payment — Cash, Check, Visa / Mastercard.

NO INTEREST[1] Payment Plans[2] from CareCredit:

- Allow you to pay over time with no interest[1]
- Convenient, low monthly payment plans[2] also available
- No annual fees or pre-payment penalties

Please note: Modern Dental Concepts requires payment at time of service. For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill insurance for reimbursement of your treatment. As a courtesy to you, we will do our best to estimate your portion due at time of service. Any unpaid balance remaining after insurance reimbursement will be your responsibility. Insurance never guarantees payment, and services can be denied for any reason your insurance plan deems necessary.[3]

Modern Dental Concepts charges $40 for returned checks. An 18% finance charge will accumulate for any unpaid balances that are over 60 days at the office. A form of payment through a credit / bank card is required to be kept on patient file. Patient understands and agrees to have their balance of $75.00 or less automatically charged to their card on file after all insurance payments have been applied.

In consideration of the service to be provided to the patient, I / we hereby guarantee payment in full of the customer's account in accordance with the financial arrangements made at the time of service / purchase or, if no such arrangements are made, in the event of default in payment, reasonable collection agency fees equal to thirty percent (30%) of the delinquent balance and reasonable attorney fees shall be added to the amount due on the account, plus any applicable court costs.

You expressly consent and agree that Modern Dental Concepts and their affiliates, agents, and service providers may use written, electronic, or verbal means to contact you. This consent includes, but is not limited to, contact by manual methods, prerecorded or artificial voice messages, text messages, emails, and / or automatic telephone dialing systems. You agree that Modern Dental Concepts and affiliates, agents, and service providers may use any email address or any telephone number you provide, now or in the future, including a number for a cellular phone or other wireless device, regardless of whether you incur charges as a result.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you deserve.

Patient Name (please print):	Date:
Signature:	

[1] If paid within the promotional period. Otherwise, interest is assessed from the purchase date. Minimum monthly payment required.
[2] Subject to credit approval.
[3] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.