Welcome to Enchantment Dental

Name_____SS#_____(Needed to file your insurance)

Address_____

City_____State_____Zip Code_____Birthdate_____

Email_____Preferred phone_(_____)_____

Work place_____Work Phone _(_____)_____

Emergency Contact_____Phone_(_____)_____

Office and payment policies

1. We are happy to file all insurance paperwork for you, however please know you are ultimately responsible for all fees incurred at this office. Co-payments with insurance generally range from 50% to 80% for fillings and crowns with a $50 deductible. Most insurance companies cover X-rays, exams and cleanings at 100%. These are generalities, your insurance may vary on these benefits

2. Estimated co-payments are due at time of service. If you are a self pay patient, payment at the time service is required. If you have any questions regarding the amount due, please feel free to ask prior to service being rendered. We do accept Visa, Master card, American express, and Discover card payments. Returned check fee is $25.00. Any outstanding balances unpaid for more than 90 days will result in dismissal from care.

3. Cancellation of an appointment with less than 24 hours notice or missed appointment will incur a $50 fee. This fee is due before you will be reappointed and will not be waived.

4. Patients not seen for 18 continuous months will be considered self dismissed from the practice. Non-payment of a missed appointment or cancelled appointment fee for 90 days with also be considered self dismissed.

5. By signing below you acknowledge that you are aware of your financial obligation, and that you have received or read a copy of our office's HIPPA notice and our privacy practices. Signing below, you assign your insurance benefits be paid directly to our practice.

6. Any disputes with our office regarding payment, billing and treatment are hereby excluded from civil litigation. I hereby waive my right to any and all such proceedings.

Signature_____(required) Date_____

Primary Insurance Information: **Please also allow us to copy your insurance card for additional information.**

Insurance company_____

Information about the insured person:

Primary insured person_____Birthday_____SS#_____

Phone Number_(_____)_____Insured person's employer_____

Relationship to insured person_____

Medical History

Current medical conditions/diseases:_____

_____

_____

Current Medications:_____

_____

_____

Any Allergies?_____

Circle any of the following that you have experienced:

Liver Disease Diabetes Lung Disease Heart Disease Cancer

Brain Injury or Epilepsy Infectious Disease (HIV, Tuberculosis, Hepatitis) Kidney Disease

_____

The following conditions directly effect dental treatment circle any that effect you:

Joint Replacement Bleeding disorders Radiation treatments Smoking

Medications for bone density Pacemaker Heart valve disease Reactions to local anesthetics

_____

Have you been vaccinated for COVID 19? Y/N

Women only: Are you pregnant? Y/N Are you nursing? Y/N

Have you ever had any reaction to dental local anesthetic? Y/N

Do you currently have any pain or other concerns regarding your teeth, mouth or gums? Y/N

_____

I certify that I have read and undressed the above information. To the best of my knowledge I have accurately answered the questions. I understand that providing incorrect information is dangerous to my health.

Signature of Patient or Guardian_____Date_____

_____

HIPPA NOTICE OF PRIVACY PRACTICES
ENCHANTMENT DENTAL, PC
1442 A ST. FRANCIS DRIVE SANTA FE, NM 87505

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Uses and disclosures of protected health care information:

A. Treatment: We will use and disclose your personal information to provide, coordinate, or manage your health care and related services. This includes communications with a third party such as insurance company or home health agencies.

B. Payment: Your protected information may be used to file insurance.

C. Health Care operations: Your protected information may be used in business activities such as quality assessment, training, licensing and other related business activities. These include phone messages in order to confirm treatment times and descriptions of treatment, unless you ask that these messages not be left.

Other disclosures made not in the context of your dental care and business relations may be made only with your consent.

2. Your Rights:

A. Your have the right to inspect and copy your protected health information. In most cases a written request for your records will require 72 hours to copy.

B. You have the right to request a restriction of your protected health information.

C. You have the right to receive confidential communications from us by alternative means or at an alternative location.

D. You have the right to have the Dentist amend your protected health information.

E. You have the right to receive an accounting of the certain disclosures we have made, if any, of your protected health information.

3. Complaints:

You may complain to us or the Secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact (Theo Krupp, Office Manager) of your complaint. We will not retaliate against you for filing a complaint.

PLEASE TAKE THIS NOTICE WITH YOU

NOTICE EFFECTIVE JUNE 1, 2005