MOUNTAIN VIEW DENTAL & ORTHODONTICS

2081 East First Street * Alamogordo, New Mexico 88310

Patient Information:

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Title: Mr./ Ms./ Mrs. Gender: Male / Female

Family Status: Married / Single / Child / Other

Birth Date: _____ SS#: _____-_____-_____ Prev. Visit: _____

Email Address: _____ Best time to call:_____

Phone: _____ _____ _____ _____ _____

Home Work Ext Mobile Other

Address: _____

City: _____ State: _____ Zip:_____

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip:_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than the patient, or if the patient is under 18.

Patient Name: _____ _____ _____ _____

Last First MI Preferred Name

Title: Mr./ Ms./ Mrs. Gender: Male / Female

Family Status: Married / Single / Child / Other

Birth Date: _____ SS#: _____-_____-_____ Prev. Visit: _____

Email Address: _____ Best time to call:_____

Phone: _____ _____ _____ _____ _____

Home Work Ext Mobile Other

Address: _____

City: _____ State: _____ Zip:_____

Primary Dental Insurance:

Name of Insured: _____

Insured Social: _____Insured DOB: _____

Patient relationship to insured: _____

Insurance Plan Name: _____

Insurance Company: _____

Insurance Subscriber ID: _____

Employer of Insured: _____

Secondary Dental Insurance:

Name of Insured: _____

Insured Social: _____Insured DOB: _____

Patient relationship to insured: _____

Insurance Plan Name: _____

Insurance Company: _____

Insurance Subscriber ID: _____

Employer of Insured: _____

How did you hear about our practice?

Family / Friend Radio Postcard in the Mail Movie Theater Website Facebook

Whom may we thank for referring you to our practice? _____

In an emergency who should be notified? _____ Phone: _____

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Office Policies

It is our goal to provide our patients with friendly service, timely appointments, and reasonably priced treatment. Achieving these goals requires the help and cooperation of each patient.
Listed below are our expectations. Should you have any questions or comments, please feel free to speak with our front office staff.

1. **Appointment Times** – Your appointment time is based on the time we expect to have you seated in the treatment area. In order to stay on schedule, **please arrive 5-10 minutes ahead of your appointment time.**
2. **Payments** – **Payment for treatment is due the day of service**, unless other arrangements have been made in advance. **Patient's copays are based on expected insurance settlements and are an estimate ~ Not a Guarantee.**
3. **Returned Checks** – Checks returned for any reason will result in the patient being charged the original amount of the check, a **$20.00 return check fee**, and handling fees charged by the bank.
4. **Insurance Payments** – Due to delays in information updates, it is not always possible to avoid insurance payments being denied. Should this happen, **the remaining balance is the responsibility of the patient.**
5. **Change/Cancellation of Appointments** – Must be done **no less than 24 hours** in advance, as this time has been reserved specifically for you. If the office is closed, please leave a message.
6. **No Show Charge** – Any patient not giving a minimum 24 hour notice of cancellation will be charged a **$50.00 fee** for the reserved treatment time.
7. **Children's Cleaning Visits** – Parents are **encouraged** to sit in on all cleaning visits, to learn your child's brushing habits and to be present when the Dentist does the exam, for an explanation of any needed treatment.
8. **Cell Phones – Are PROHIBITED beyond the waiting area. No usage is permitted in any of the treatment rooms. Please turn them off when you are called back for your appointment.**

_____

Patient's Printed Name

_____

Patient/Guardian's Signature Date

Telephone 575.437.7900 Fax 575.437.7922

2081 East First Street * Alamogordo, New Mexico 88310

Consent to Dental Treatment

Patient's Name: _____ **Date:**_____

I hereby authorize Mountain View Dental and Orthodontics (Dr. Westover, Dr. Slade, Dr. Carlen, Dr. Miller, Dr. Saperstein and their associates) to perform upon me or the named patient the procedures discussed. Dr. Westover or his Associate(s) has explained to me the purpose of the procedure and has also explained to me the expected benefits and possible complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to the proposed treatment, including opportunity to ask questions, and all my questions have been answered fully and satisfactory. I acknowledge that no guarantees or assurances have been made to me concerning the results intended form the procedure(s).

I understand that during the course of the procedure(s) unforeseen conditions may arise which necessitate procedures different from those expected. I, therefore, consent to the performance of additional procedure(s) which the above-named Dentist or his Associate(s) may consider necessary.

I understand that I am responsible for all fees regardless of insurance coverage. I also understand that as treatment progresses, the above fees may have to be adjusted, but that I will be informed of these adjustments and how they will affect my payment plan. In the event that my payments are not received within 30 days of their due date, I agree to pay all costs of collections including, but not limited to reasonable attorney's fees.

I hereby consent to the proposed dental treatment.

_____

Patient's Name

_____

Patient/Guardian's Signature Date

_____

Signature of Witness Date

_____

Date

Telephone 575.437.7900 Fax 575.437.7922

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HIPPA Privacy Policy Consent Form

Complaints:

Complaints about your privacy rights or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles you complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

Please provide the name(s), if any, that we may share your dental treatment or any personal information with:

_____

_____

_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and heath care operations as described in the Privacy Notice.

_____

Patient's Name Printed

_____

Patient/Guardian's Signature Date

_____