Ramstein Dental Care

Wiesbaden Dental Care

# New Patient Registration

**Alerts:**

## Patient Information

Last Name: _____ First: _____ Birth Date: _____

I prefer to be called: _____ SSN: _____ ☐ Male ☐ Female

Please Circle: **PSC or CMR #** _____ Box # _____ APO AE _____

Local Address: _____

☐ Minor ☐ Single ☐ Married **DEROS:** _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Has anyone in your family been seen here before? **YES or NO**

If yes, what is their name? _____

**Sponsor's Information or Main Subscriber:** _____ SSN: _____

Birth Date: _____ Relation to Patient: _____

Phone Number: _____ Email: _____

Employer: _____ Unit: _____

## Primary Dental Insurance Information

Insured Name: _____

Relation: _____

Insurance Company: _____

Account Number: _____

Group Number: _____

## Secondary Dental Insurance Information

Insured Name: _____

Relation: _____

Insurance Company: _____

Account Number: _____

Group Number: _____

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Wiesbaden Dental Care

# New Patient Health History

Patient Name: _____ Birth Date: _____

## Dental History

**Please check any of the following that apply to you:**

- ☐ Sensitivity (hot, cold, sweets, pressure)
- ☐ Discomfort when chewing
- ☐ Jaw pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, chipped, or shifting teeth
- ☐ Bad breath or bad taste in your mouth

**Do you have, or have you ever had any of the following?**

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

What is the reason for your visit today?

_____

**How can we help you improve your smile?**

- ☐ Whiten
- ☐ Straighten
- ☐ Close Spaces
- ☐ Repair silver fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match other teeth

_____

Name of Previous Dentist

_____

Phone Number

## Medical History *(please circle Y or N)*

Y N - AIDS / HIV Positive
Y N - Anemia
Y N - Arthritis
Y N - Artificial Joints
Y N - Asthma
Y N - Blood Disease
Y N - Blood Thinner
Y N - Cancer
Y N - Codeine Allergy
Y N - Diabetes 1 / 2
Y N - Dizziness
Y N - Epilepsy
Y N - Excessive Bleeding
Y N - Fainting
Y N - Glaucoma
Y N - Head Injuries
Y N - Heart Disease
Y N - Heart Murmur
Y N - Hepatitis A / B / C
Y N - High Blood Pressure
Y N - Jaundice
Y N - Kidney Disease
Y N - Latex Allergy
Y N - Liver Disease
Y N - Mental Disorders
Y N - Nervousness/Depression
Y N - Penicillin Allergy
Y N - Pregnant (currently)
due date: _____
Y N - Radiation Treatment
Y N - Respiratory Problems
Y N - Sinus Problems
Y N - Stent
Y N - Stomach Problems
Y N - Stroke
Y N - Tobacco user (currently)
Y N - Tuberculosis
Y N - Tumors
Other: _____

_____

**Are you taking any medications?** Yes or No

If yes, please list all medications:

_____
_____
_____
_____
_____
_____

**Do you have any allergies?** Yes or No

If yes, please list all medications:

_____
_____
_____
_____
_____
_____

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

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Wiesbaden Dental Care

# Office Policies

**Please initial after reading the following information:**

_____**Payment is due** at the time services are rendered. Please note that payment of your bill is considered part of your treatment. For your convenience we accept cash, Giro card, Visa, and Mastercard. **All prices are in euro.**

_____**Insurance benefits** are determined by your employer. Insurance is not a guarantee of payment; it may not cover all your costs. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. ***Payment to Wiesbaden Dental Care is ultimately your responsibility.*** As a courtesy we will file your claim if eligible. Please provide us with your dental insurance card prior to your appointment.

• **Tricare/United Concordia Patients:** As a courtesy to you, and as a Tricare/United Concordia preferred provider, we will help you process all your dental claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. ***All charges you incur are your responsibility regardless of your insurance coverage.***

_____**It is the Patient's responsibility to ensure all contact information is up-to-date and correct.** We will E-mail and call you as a courtesy a week prior to your appointment and the day before your appointment by 1100. This however is a courtesy, not a policy or requirement. ***If you do not confirm your appointment within the allotted time, then your appointment is not guaranteed.***

_____**Continuity and consistency of care** are key to maintaining proper dental health. Maintaining a relationship with our patients is our priority. Your appointment is reserved exclusively for you; therefore, courtesy of advance notice when you are unable to keep an appointment is appreciated and required. ***When you do not show up to your appointment, or cancel too close to your appointment time, we are unable to fill this time. After this, there will be a €50,- fee per hour of scheduled time missed.*** This policy is our attempt to ensure that both you and our other patients receive the dental care needed. Broken appointments are defined as:

· Any time you are scheduled for an appointment and you do not show for that appointment.

· Late cancelations. If you need to cancel your appointment, we ask that you call us by 1100 the day prior.

· Late arrivals. If you do not arrive by 10 minutes after the start time of your appointment, you will have missed too much of the appointment's time.

**We reserve the right to dismiss any patient from the practice who misses or cancels, without at least 24-hour notice, three or more appointments. Furthermore, patients who consistently change appointments with or without notice may also be subject to dismissal. Appointment changes must be made directly through the office.**

_____**Wiesbaden Dental Care operates under a zero-tolerance policy toward** disrespectful and unruly behavior. Patients who disrespect any Dentist or employee will immediately be refused treatment and all scheduled appointments will be removed.

_____**An adult parent or legal guardian** must accompany all minor patients (under 18 years of age) and ***must remain inside the building at all times*** throughout your child's dental appointment. If an authorized adult other than the parent or legal guardian is present at your child's appointment, it is important that we have documents signed by the parent or legal guardian prior to your child's appointment.

***I have read, understand, and agree to the above terms and conditions.***

_____ _____

Patient or Guardian Signature Date

Ramstein Dental Care

Wiesbaden Dental Care

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in effect in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and are. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

**We have adopted the following policies:**

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories. Health insurance payers as is necessary and appropriate for your care. Patient files may be stored on our computers and in open file racks. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ on this day _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Ramstein Dental Care

Wiesbaden Dental Care

# HIPAA Email Consent

**VERY IMPORTANT! PLEASE READ!**

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- ***Information stored on our computers is not encrypted***
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- ***When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.***
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Wiesbaden Dental Care to send me personal health information via unencrypted email.

_____ _____

**Patient or Guardian Signature** **Date**

_____ _____

**Patient's printed name** **Please print email address**

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information and reminder emails for my next appointments.

_____ _____

Patient or Guardian Signature Date

Ramstein Dental Care

Wiesbaden Dental Care

## TriCare Dental Coverage **Active Duty Dependents Only Command Sponsored? Yes or NO**

**The TDP cover the following services 100% with command sponsorship:**

*Comprehensive and Limited Exams – 1x12 months
*Periodic Exams, Cleanings, and Fluoride Treatments – 2X12 months
*Bitewing X-rays – 1x12 months
*Panoramic/Full Mouth X-ray – 1x36 months

**The following services are covered at 100% up to your benefit level with command sponsorship:**

*Full Mouth Debridement and Perio Scaling/Root Plan (SRP)– 1x24 months
*Periodontal Maintenance – 4x12 months
*Fillings – 1x12 months
*Root Canal Treatments and Retreatments – 1 per Lifetime
*Extractions (Wisdom Teeth ages 15 to 30, all other need pre-authorization)
*Night Guards due to Bruxism or Teeth Grinding – 1x12 months age 13 and older
*Sealants – 1x36 months up to age 18
*Athletic Mouth Guards – 1x12 months
*Orthodontic Consults – up to age 20, if enrolled full time in an accredited college or spouse age 22, **Non-Availability and Referral Form (NARF) required for orthodontics**

**There is a 50% co-pay for the following services up to your benefit level:**

*Crown Build-Up – 1x60 months
*Crowns, Onlays, Inlays – 1x60 months
*Bridges & Dentures – 1x60 months
*Re-cementing Crowns – 1x12 months
*Implants – with pre-approval – 1x60 months
*Orthodontics – up to age 20, if enrolled full time at an accredited college, or spouse aged 22, **Non-Availability and Referral Form (NARF) required for orthodontics**

**Non-Covered Services:**

*N2O
*Occlusal Adjustments
*Sedative Fillings
*Bleaching Trays
*Veneers, Whitening
*Brush/Hard and Soft Tissue Biopsy

***Non-command sponsorship makes the patient responsible for any incurred cost of all services.***

Every patient has a **$1500 USD (approx. €1250)** worth of benefits per year. **Tricare's benefit year starts May 1st and ends April 30th.**

******All charges you incur are your responsibility regardless of your insurance coverage******

I have read, understand, and agree to the above:

_____ _____

**Patient or Guardian Signature** **Date**

UNITED CONCORDIA®

## Appointment of Individual to Act as Appeal Representative

I appoint Wiesbaden Dental Care/Ramstein Dental Care to act as my representative in connection with my appeal under Code of Federal Regulations, Chapter 32, Section 199.13, Appeal and Hearing Procedures. I further authorize the TRICARE Management Activity (TMA) and United Concordia Companies Inc., to release to said representative, information related to my dental treatment, and if necessary, photocopies of any dental records which may be required for adjudication of my claim for TRICARE Dental Program (TDP) benefits. Please return the completed form to: United Concordia Companies, Inc TDP Customer Service P.O. Box 69410 Harrisburg, PA 17106-9410

_____ Beneficiary Name

_____ Beneficiary Signature

_____ Sponsor's Social Security Number

_____ Date