Cynthia L. Graves DDS
Beautiful Smiles, Exceptional Care

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Financial Policy for Patients with Insurance

Effective February 1, 2016.

In order to provide exceptional, personalized care, Dr. Graves does not participate as a "Network Dentist" on any Dental Insurance Plans. For most "Network Plans" we are allowed to file your insurance as an "Out of Network Provider". Because we bundle procedures that are often broken out as separate line-item charges (ex: sterilization fees, OSHA fees, oral hygiene instruction, periodontal exams), your total care needs with us should be comparable in out-of-pocket costs to many "In-Network" Practices in the area.

At the time of service, Patients with Dental Insurance are allowed to pay the amount of the estimated portion not covered by their Policy.

As a courtesy, our team will file insurance claim(s) electronically for you on the date of treatment. As it is anticipated that the balance will be paid from your Dental Benefits, we will have you sign an agreement for assignment of benefits so the payment can be sent directly to us. Should the Insurance Company insist on sending their check to you directly, you are expected to remit the balance to us within 10 calendar days.

Please understand that we have no control over your Dental Insurance Benefits. We subscribe to a service that assists us in determining an estimate of what your Dental Benefits may pay but, this is not a guarantee of payment by your Insurance Company.

In reality, Dental Insurance isn't really insurance (a payment to cover the cost of a loss). It is a financial benefit to help pay for routine Dental Care. In our experience, most Dental Benefits cover only a portion of our Patients' total care needs and are subject to either an annual cap and/or a downgrade in the recommended care to an option that is less costly. It is important for you to remember that the dental insurance coverage is a contract between you and the Insurance Company. That contract is based on actuarial studies, not your long-range personal clinical needs.

If your insurance benefit has not been paid within 90 days of when we file your claim, you will be asked to make payment for the balance owed on your account for that claim. In some cases, we can extend our services to continue to pursue the claim, but in many cases, the Patient is more successful in pursuing payment of the claim with their Insurance Company. Based on our experience, success in processing claims varies from plan to plan. If an insurance payment is issued to us after the 90-day period, and you have paid for the service/claim in full, we will initiate a refund to you within 5 business days.

In some cases, your Medical Insurance may provide coverage for specific treatment. At this time the covered services are limited to 3D Cone Beam Scans, Surgical Procedures and Treatment for Trauma. In these cases, we can process a medical claim for you. Due to the unpredictable nature of Medical Insurance reimbursement, we are unable to extend the same payment arrangements we provide for chargeable service as Dental Insurance.

Hopefully, we will experience an expansion of services that are covered by Medical Insurance in the future.

Cynthia L Graves, DDS Ltd LLP is NOT a Medicare or Medicaid provider.

My signature below indicates my understanding and acceptance of the terms related to Insurance Benefits as they relate to my account with Cynthia L Graves, DDS Ltd LLP.

I authorize payment to Dr. Graves as a designated assignment of benefits for Medical and Dental Insurance claims.

Printed Name	Signed	Date

PATIENT DENTAL HISTORY

PATIENT NAME _____

PATIENT ACCOUNT NO. _____ MEDICAL ALERT _____

	YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑
2. Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑
5. Do you have any sores or lumps in or near your mouth?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?		
a) Clicking?	❑	❑
b) Pain (joint, ear, side of face)?	❑	❑
c) Difficulty in opening or closing?	❑	❑
d) Difficulty in chewing?	❑	❑

	YES	NO
8. Do you have frequent headaches?	❑	❑
9. Do you clench or grind your teeth?	❑	❑
10. Do you bite your lips or cheeks frequently?	❑	❑
11. Have you ever had any difficult extractions in the past?	❑	❑
12. Have you had any orthodontic work?	❑	❑
13. Have you ever had prolonged bleeding following extractions?	❑	❑
14. Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
15. Have you ever had instructions on the care of your gums?	❑	❑

What is the reason for your visit today? _____

_____

Date of last dental visit _____

What was done at your last dental visit? _____

_____

Do you have any dental problems now? YES NO

If yes, please describe: _____

_____

Are you satisfied with the appearance of your teeth? YES NO

What would you change about your smile? _____

Do you brush, floss or use any other dental aids? _____

Is there anything else about having dental treatment that you would like us to know? YES NO

If yes, please describe _____

Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X _____

PATIENT, PARENT OR GUARDIAN DATE

Continued on back ➔

Time 10:07 AM | Cynthia L. Graves DDS LTD., LLP | Date 10/15/2015

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____