Dear Valued Patient,

Vista Family Dentistry would like to welcome you as a new patient. We are looking forward to meeting you at your initial visit on _____. Enclosed is a new patient packet with forms that we ask for you to please fill out and bring with you to your appointment.

If you think that you might have current x-rays on file at your former dental office, please ask them to e-mail them to our office prior to your appointment at **office@vistawi.com.**

We do request that patients without dental insurance be prepared to pay at the time of service.

Again we look forward to meeting you, and thank you for giving us the opportunity to assist you in achieving your dental goals.

Sincerely,

The Vista Family Dentistry Team

Vista Family Dentistry Patient Registration Form

Record # (office use): _____ **Relation:** Self Spouse Child Other
Responsible Party Name (person to bill): _____
Patient Name _____
First Middle Last
Preferred Name (nickname): _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Work Phone:** _____
Mobile Phone: _____ **Email:** _____
Birthdate: _____ **Social Security Number:** _____
Gender: Male Female **Marital Status:** Single Married Other
Emergency Contact Person: _____ **Phone:** _____
Who can we thank for this referral? _____
Preferred method(s) of contact (please circle any/all): email text call

****

Insurance Information

This office will be happy to assist in every way we can with the processing of insurance claims and estimates. **Patients are responsible for charges not covered by their insurance.** Please be aware of your deductibles, percentage co-pay, dates of coverage, etc.

Primary Insurance:

Relation to Insured: Self Spouse Child Other **Subscriber Name:** _____
Subscriber Date of Birth: _____ **Subscriber SSN:** _____
Insurance ID Number: _____ **Group Number:** _____
Insurance Carrier: _____
Name Address
Employer: _____ **School Name** (If student): _____
Employment Status: Full Time Part Time Full Time Student Part Time Student

****

Secondary Insurance (If applicable):

Relation to Insured: Self Spouse Child Other **Subscriber Name:** _____
Subscriber Date of Birth: _____ **Subscriber SSN:** _____
Insurance ID Number: _____ **Group Number:** _____
Insurance Carrier: _____
Name Address
Employer: _____ **School Name** (If student): _____
Employment Status: Full Time Part Time Full Time Student Part Time Student

Signature: _____ **Date:** _____

Vista Family Dentistry Health History Form

Date _____

Patient Name (First, MI, Last): _____ D.O.B: _____ Age: _____

Name of person completing this form: _____ Relationship to patient _____

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

Medical History

1. Do you have any health problems? Yes No
   If yes, please describe: _____
2. Have there been any changes in your health in the past year? Yes No
3. Are you currently under medical care? Yes No
   If yes, for what? _____
4. Are you taking any medications, pills, or drugs? Yes No If yes, please list on attached form.
5. Has a doctor or dentist recommended that you take routine antibiotic premedication prior to your dental treatment? Yes No
6. Have you had an orthopedic total joint replacement? Yes No Date? _____ Any Complications? _____
7. Have you taken bisphosphonate/antiresorptive agents for osteoporosis, Paget's Disease, cancer treatments, or hypercalcemia (ex: Alendronate, Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA)? Yes No

8. **WOMEN ONLY:**
   Are you pregnant? Yes No
   If yes, please list number of weeks: _____
   Are you taking birth control pills/hormonal replacement? Yes No
   Are you nursing? Yes No

9. Do you have any of the following **Allergies?** ☐ No Known Allergies
   ☐ Aspirin ☐ Codeine ☐ Dental Anesthetics (Novocaine) ☐ Iodine ☐ Latex
   ☐ Metals ☐ Pain Medication ☐ Penicillin/Amoxicillin ☐ Other _____

10. Do you have or have you ever had any of the following?

Artificial (Prosthetic) heart valve	Yes	No	Previous infective endocarditis	Yes	No
Damaged valves in transplanted heart	Yes	No	Unrepaired, cyanotic congenital heart disease	Yes	No
Repaired congenital heart disease with residual defects	Yes	No	CHD repaired completely in last 6 months	Yes	No

Except for the conditions listed above, antibiotic premedication is no longer recommended for any other form of heart disease.

11. Do you currently have or have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	NO
Cardiovascular disease	☐	☐	Sexually Transmitted Disease	☐	☐	GI Disease	☐	☐
Angina	☐	☐	HIV/AIDS	☐	☐	Reflux/Heartburn	☐	☐
Arteriosclerosis	☐	☐	Chronic Cold Sores	☐	☐	Osteoporosis	☐	☐
Congestive Heart Failure	☐	☐	Arthritis	☐	☐	Chronic Pain	☐	☐
Damaged Heart Valves	☐	☐	Autoimmune Disease	☐	☐	Muscular Disorder	☐	☐
Heart Attack	☐	☐	Rheumatoid Arthritis	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Lupus	☐	☐	Hepatitis A, B, or C	☐	☐
Chest Pain w/Exertion	☐	☐	Asthma	☐	☐	Epilepsy	☐	☐
High/Low Blood Pressure	☐	☐	Bronchitis	☐	☐	Fainting/Seizures	☐	☐
Congenital Heart Defects	☐	☐	Emphysema	☐	☐	Neurological Disorders	☐	☐
Stroke	☐	☐	Tuberculosis	☐	☐	Multiple Sclerosis	☐	☐
Pacemaker	☐	☐	Sinus Trouble	☐	☐	Mental Health/Psychiatric Disorders	☐	☐
Blood Transfusion	☐	☐	Cancer/Chemo/Radiation	☐	☐	Autism Spectrum	☐	☐
Rheumatic Fever	☐	☐	Sleep Apnea	☐	☐	ADHD/ADD	☐	☐
Rheumatic Heart Disease	☐	☐	Kidney Problems	☐	☐	Headaches/Migraines	☐	☐
Abnormal Bleeding	☐	☐	Diabetes Type I or II	☐	☐	Tobacco Use	☐	☐
Blood Disorders	☐	☐	Thyroid Problems	☐	☐	Alcohol Abuse	☐	☐
Hemophilia	☐	☐	Eating Disorder	☐	☐	Drug Use/Abuse	☐	☐

Patient/Guardian Signature: _____ Dentist Signature: _____

Vista Family Dentistry Current Medication List

Patient Name: _____ Date: _____

Are you currently taking any prescription medications, over the counter medications, herbal or dietary supplements?

Yes _____ No _____

Medications	Reason Taking	How much	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Patient Signature: _____

Dentist Signature: _____

Vista Family Dentistry Dental History Form

Patient Name (First, MI, Last): _____ D.O.B: _____ Age: _____

1. What is the reason you are seeking dental treatment? _____

_____

2. **YES NO** Are you currently experiencing pain or discomfort? Explain: _____
3. Approx date of your last dental exam? _____ Date of your last x-rays? _____
4. **YES NO** Do you brush your teeth? How often? _____
5. **YES NO** Do you floss your teeth? How often? _____
6. **YES NO** Do your gums bleed when you (please circle): brush floss
7. **YES NO** Are your teeth sensitive to (please circle): Cold Hot Sweets Pressure Biting
8. **YES NO** Do you have dry mouth (xerostomia)?
9. **YES NO** Have you had periodontal (gum) treatments or deep cleanings?
10. **YES NO** Have you ever had orthodontic (braces) treatment?
11. **YES NO** Have you ever had problems associated with previous dental treatment?
12. **YES NO** Has fear or behavior ever prevented you from receiving dental treatment?
13. **YES NO** Do you have earaches or neck pain?
14. **YES NO** Do you have clicking, popping, tightness or discomfort in your jaw (TMJ)?
15. **YES NO** Do you clench or grind your teeth (bruxism)?
16. **YES NO** Do you have sores or ulcers in your mouth?
17. Do you wear (please circle): Dentures Partials Biteguard
18. **YES NO** Do you participate in active recreational activities?
19. **YES NO** Have you ever had a serious injury to your head or mouth?
20. Do you have (please circle): Fillings Crowns Bridges Root Canals Implants
21. Do you consume (please circle): Candy Soda Gum How Often? _____
22. **YES NO** Do you snack between meals?
23. **YES NO** Is there fluoride in your home water supply?
24. How do you feel about your smile? _____

Patient Signature (or parent/guardian): _____ Date: _____

Dentist Signature: _____ Date: _____

Vista Family Dentistry Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain health conditions may create a risk of serious or fatal complications. Please advise your dentist of any health conditions you (or your minor child) may have, so they can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition, which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication.
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

PATIENT PORTION ↓

_____ _____

Patient Signature (Parent/Legal Guardian) Date

_____

Print Patient Name

OFFICE PORTION ↓

_____

Witness Signature

_____

Witness Date

VISTA FAMILY DENTISTRY
WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin Law for our use and disclosure of the patient's dental care records to carry out treatment, payment activities, and health care operations.

SECTION A: *Individual giving consent.*

Patient Name: _____ **Date of Birth:** _____

Name of Legal Guardian (if minor patient)/Relationship: _____

Address: _____ **Tel:** _____

Is there any other person with whom we may discuss your treatment or account? _____**Yes (list name(s) below)** _____**No**

{Person's Name}	{Relationship}	{Phone Number}
{Person's Name}	{Relationship}	{Phone Number}

TO THE INDIVIDUAL: Please read the following and complete the information requested

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

SECTION B: The uses and disclosures being authorized.
Our Use of Dental Health Information: By signing this form you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Signing This Consent Is Not Limited to, but Does Allow Us To:

*Send you appointment reminder post cards.
*Leave voice mail or recorded messages regarding appointments.
*Leave voice mail or recorded messages regarding the need for pre-medication or medication required for dental treatment.
*Communicate by phone or in writing with your insurance company.
*Communicate by phone or in writing with specialists involved with your care.
*Communicate dental concerns and information with a responsible family member or guardian.
*Communicate information regarding your care with pharmacies designated by you.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Signature: Date:

In signing this form I am confirming that all the information that I have provided on the Health History Form is true and up to date.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person. Please understand that revocation of this Consent will not affect any action we took in reliance on this authorization **before** we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent

VISTA FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES

Effective Date: June 1st, 2017

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Vassilis K Panagopoulos, DDS Telephone: (262) 717 - 9104 Fax: (262) 717 - 9105

Email: office@vistawi.com Address: 20855 Watertown Rd. Suite 120, Waukesha, WI 53186

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

VISTA FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have been informed of or have received a
(print guardian, or patient name if 18yrs or older)

copy of this office's Notice of Privacy Practices.

_____
{Please Print Patient Name}

_____
{Guardian or Patient Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other {Please Specify}

_____

_____

_____

Vista Family Dentistry Financial Agreement

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you and your family with comprehensive dental care using current techniques and high quality materials. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage.

Although our practice is able to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. It is important you understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company.

Insurance payments are typically received within 30-60 business days from the time of billing. Any remaining balance after your insurance has settled a claim and/or paid is your responsibility. If your insurance company has not made a payment to our practice within 60 days, we will ask you to pay the balance and you will be responsible for seeking reimbursement from your insurance company.

Although we can provide an estimate upon request, our practice does not guarantee your insurance company will assist with payment for your treatment. If your claim is denied, you will be responsible for paying the balance in full (please see payment options below). Please note that we will submit any and all necessary documentation your insurance company requests but we will not enter into a dispute with your insurance company over any claim. It is your responsibility to resolve any type of dispute with your insurance company.

Vista Family Dentistry Payment Information:
We will send you a monthly statement.
We accept Cash, Check, Visa, Discover, MasterCard, and American Express.
We offer a 10% Senior Discount to patients (not their family members) at age 65 and older.
We request that patients without dental insurance be prepared to pay at the time of service.
We accept CareCredit. CareCredit offers third party deferred interest financing options upon approval. For more information or to apply, visit www.carecredit.com.

Please note if your balance is not paid in full, interest rates may apply

If none of these are an option for you, please see a member of our office staff and they may be able to assist you with another option or a payment plan.

Patient Name: _____ Date: _____

Patient Signature (or parent/guardian): _____