American Dentistry

Dental MVZ Doryumu & Kollegen GmbH

PLEASE BE ADVISED ALL CHARGES ARE IN EURO

PATIENT INFORMATION:

Patient's Name: ____

(First Name) (Last Name)

Sex: ☐ M ☐ F

DOB: ______________________ Marital Status: ______________________

Sponsor Information: ____

(First Name) (Last Name)

Sponsor SSN #: ____

Sponsor Squadron/ Unit: ______________ Deros: ______________

German Home Physical Address:

Street: ______________________

City: ______________________

Zip: ______________

Cell Phone: (_____) ______________________

Email: ______________________

APO/CMR Address:

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EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? ______________________________

Relationship to Patient: ______________________ Phone: (_____) ______________

INSURANCE COVERAGE: (we will need to make a copy of your cards – please provide your cards)

Primary Company Name: ______________________________

Secondary Company Name: ______________________________

Appointment Reminders:

Please be advised that appointment reminders are done via email only. Cancellations must be done 24 hours prior to appointment to avoid penalty charges.

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?

- ☐ Whitening
- ☐ 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

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

Y N - High Blood Pressure

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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 - Jaundice
Y N - Kidney Disease
Y N - Latex Allergy
Y N - Liver Disease
Y N - Mental Disorders
Y N - Anxiety/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:

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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:

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____
____
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Signature of Patient/Legal Guardian: __________________________ Date: ____________________________

Patient Printed Name: ______________________________________ Date: ____________________________

TriCare Dental Coverage

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 (Teeth Grinding) – 1x12 months age 13 and older
*Sealants – 1x36 months up to age 18
*Athletic Mouth Guards – 1x12 months

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 21 if command sponsored. If enrolled full time at an accredited college age 23.

Non-Availability and Referral Form (NARF) required for orthodontics

Non-Covered Services:

*Pulp Caps
*N2O
*Occlusal Adjustments
*Sedative Fillings
*Bleaching Trays
*Veneers, Whitening
*Brush/Hard and Soft Tissue Biopsy
*Orthodontic Initial Consultation

Non-command sponsorship makes the patient responsible for 100% of the 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**

Financial Policy

Welcome to American Dentistry! Thank you for selecting us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. The following is a statement of our financial policy, which we require you read, agree to, and sign, prior to any treatment. Payment is due at the time service is provided. Our office accepts euro, Giro card, Visa, and MasterCard as payment.

- Tricare/United Concordia Patients: As a courtesy to you we will help you process all your dental claims. 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 will determine the amount paid. We will 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.**

- Private Insurance Plans: Patients with all other insurances will pay the total fee up front at the time of your appointment. We will assist you by printing your insurance claim and explaining the process of reimbursement from your insurance carrier. As your dental provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.

I have read, understand, and agree to the above terms and conditions. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I also understand any services not covered by my insurance plan or denied by my insurance plan are my responsibility to pay**. I understand my information will be given to a debt collections company (Creditreform) after 90 days if no payment agreement has been come to and my account is delinquent.**

______________________________ ________________

Patient and or Guardian Signature **Date**

Landstuhl American Dentistry Appointment Cancellation/No Show Policy

Thank you for trust your dental care in Landstuhl American Dentistry. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment please contact our office **no later than 24 hours** prior to your schedule appointment. This gives us time to schedule other patient who may be waiting for an appointment. Please see your Appointment Cancellation/ No Show Policy below:

Effective June 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours** will be considered a No Show and charged a **25 Euro fee.**
Any established patient who fails to show or cancels/reschedule an appointment with no 24 hours' notice a **second time** will be charged a **50-euro fee.** If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from Landstuhl American Dentistry.

The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next visit.
We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your schedule appointment. If you should experience extenuating circumstances please ask for an Office Manager, who may be able to waive the No Show fee.

I have read and understand the Appointment Cancellation/ No Show Policy and agree to its terms.

______________________________	_____________________________________
Signature	Relationship to Patient
_____________________________	______________________________________
Printed name	Date

Informed Consent

I authorize Dr. Doryumu, Dr. Pfitzer, and/or such associates or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health, or of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary or, rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings, bleaching, and basic dentistry such as fillings of all types, teeth remain sensitive or even possibly quite painful, both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.

Payment for dental services should be made immediately following treatment, unless other arrangements have been made prior to treatment.

I authorize the dentist to release information including the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or other health practitioners.

I hereby do abide by the conditions outlined herein.

______________________________________	______________________________________
Signature	Date

American Dentistry
Kaiserstrasse 26
66849 Landstuhl

HIPAA - DECLARATION OF CONSENT

THIS IS MY CONSENT FOR THE STORAGE OF MY PERSONAL DATA IN ACCORDANCE WITH THE FEDERAL DATA PROTECTION ACT

NAME:

DATE OF BIRTH:

GENDER: M: F:
ADDRESS:

GUARDIAN (IF APPLICABLE):

DATE:

SIGNATURE OF PATIENT:

DATE:

American Dentistry
Dental MVZ Doryumu & Kollegen GmbH
Kaiserstrasse 26
66849 Landstuhl

Information on Data-Protection and Data-Security in our practice

Dear Patient,

On May 25, 2018, the European Data Protection Regulation and the new Federal Data Protection Act enter into force. The protection of personal data of EU citizens is hereby strengthened.

As your dental practice, we have always enforced great importance to the security of your personal information that we collect as part of your treatment. Nevertheless, the European Data protection Act obliges us to inform you about which of your data we collect, for what purpose, save, pass on or share.

ON WHAT BASIS DO WE COLLECT YOUR DATA?
Data processing takes place either due to legal requirements – in order to fulfill the legal basis between patient and dental-office, or because you have consented to the date processing. The legal basis processing your data is, for example, the European Data Protection Regulation, the new federal Data Protection Act and the federal regulations of social codes.

If we need your consent for the data processing, you can revoke or restrict this at any time with effect for future use.

You have the right to be informed as to what personal information is needed or requested. You can also request the correction of false information or data. In addition, under certain conditions, you have the right to delete certain data, the right to restrict data and the right for data- portability.

WHICH OF YOUR DATA DO WE COLLECT?
At the first contact in the quadrant, your electronic Health Card (eGK) will be submitted into our electronic administration system (PVS). The following personal information will be stored:

- Name
- DOB and gender
- Address
- Insurance Company or Provider, insurance number and status (e.g. member, dependent, retiree etc.)

Within the Scope of Treatment, we collect findings and diagnoses, plan therapies, prepare for possible medical referrals, fill out appropriate forms for prescriptions, remedies of disability forms etc. All this must be stored in a verifiable patient-related manner in our electronic administration system.

WHY DO WE COLLECT DATA AND WHAT HAPPENS WITH IT?

We require your health-data in order to be able to treat you verifiably for the Kassenzahnarztliche Vereinlgung Rheinland Pfalz (Dentistry Association Rhineland Palatinate) for their Health Insurance/Cost Unit and for your further treatments by Dentists or Physicians. Also, all Prescriptions are patient bound and require name, address, insurance provider and number. If we do not have this data, we cannot give you a prescription for a needed medication or prepare a treatment plan to be approved by the Insurance Company for reimbursement. Therefore, the data collection is an important part of your treatment.

Your data is stored on our server and is password-protected. Access to this data is restricted to authorized practioners. Your data will be stored according to the respective legally prescribed time limits. Optionally, a longer storage may be required. Overview of the statutory retention periods can be found on the page of KZV RLP https://www.kzv-rheinlandpfalz.de/praxis/dsgovo/informationspflichten-der-praxis.de

WHOM DO WE TRANSMIT YOUR DATA?

The Dentistry Association Rhineland – Palatinate (Corporation of public law) receives the data for billing with your health insurance to check for correctness.

Your health insurance company or provider of the statutory insurance system (for example, the state accident insurance fund) will receive the data relevant for billing, Dental laboratories receive data that is necessary for the making of dentures, etc. (for example, name, insurance status, treatment planning.)

Contract dental assessors and medical services for Insurance Companies receive the required information on behalf of the Insurance Company to approve a treatment plan.

At the request of the examination center, billing data must be transmitted as part of a statutory performance audit.

Laboratory physicians and/or Pathologists will receive data, if appropriate diagnostics are required for the Treatment of the Oral Cavity (for example, an oral mucosal disease).

To exercise legitimate interests of the dental practice, it may be necessary to seek help or seek judicial assistance that requires data transfer.

Other Physicians, Insurance Companies, Private accounting offices and other Institutions will receive the necessary data for the respective case only with separate consent.

If you have, any questions about data protection in our practice, our data protection officer will be happy to help you. You can reach him/her at

AMERICAN DENTISTRY **Dental MVZ Doryumu & Kollegen GmbH**

KAISERSTRASSE 36, 66849 LANDSTUHL, PHONE 06371-5608075, info@american-dentistry.de Furthermore, you have the right to ask questions about data protection or submit complaints to the Rhineland -Palatinate Data Protection Authority. STATE COMMISIONER FOR DATA PROTECTION AND FREEDOM OF INFORMATION RHINELAND_PFALZ POSTFACT 3040, 55020 MAINZ, Phone 06131-2082449, Fax 06131-2082497 e-mail: postelle@datenschutz.rip.de www.Datenschutz.rip.de