

**Moon Dental Insurance Policy:**

We process all dental insurance as out of network.

**What does this mean for you?**

You can utilize **all your insurance benefits at our office**, as long as you have **out of network coverage**. Feel free to contact our office for appointment costs. Our fees are lower than the Usual Customary and Reasonable Rate (UCR). Our team will assist you in navigating any insurance-related questions or issues.

**UNITED CONCORDIA, DELTA DENTAL, BLUE CROSS BLUE SHIELD, AND HIGHMARK INSURANCES:** Payment for services will be rendered at the time of your visit, as requested by your insurance provider. Our office will submit your claim, and a reimbursement check will be sent directly to you from your insurance company.

**ALL OTHER INSURANCES:** Our office will submit your claim. Once your claim has been processed, a statement will be sent with any balance due to our office.

We look forward to welcoming you to our outstanding dental office!

**Printed name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Drs. David and Molly Luke    Office phone number: 412-262-3190

Information is subject to change. (New patient ins letter OON - Feb 2025)

# Health History

## Moon Family & Cosmetic Dental

PLEASE PRINT

|          |             |        |
|----------|-------------|--------|
| Name:    | Birth Date: | Age:   |
| Address: | Cell Phone: | Other: |

The answers to the following questions will assist the dentist in evaluating your general health prior to providing your dental treatment. **Please read carefully and answer as accurately as possible.**

**Please Circle any of the following which you have had or have at present:**

|                          |                            |                     |
|--------------------------|----------------------------|---------------------|
| Artificial Joint         | Asthma                     | Cancer              |
| Artificial Heart Valve   | AIDS / AIDS related        | Chemotherapy        |
| Congenital Heart Disease | Anemia                     | Diabetes            |
| Heart Murmur             | Cold Sores frequently      | Stroke              |
| High Blood Pressure      | Epilepsy / Seizures        | Fainting / Dizzy    |
| Frequent Chest Pains     | Heart Disease/condition    | Thyroid Disease     |
| Hemophilia               | Hepatitis                  | Tuberculosis TB     |
| HIV Positive             | Implant Prosthesis         | Kidney Trouble      |
| Liver Disease            | Prolonged/unusual Bleeding | Radiation Treatment |
| Shortness of Breath      | Sickle Cell Disease        |                     |

|   |     |    |
|---|-----|----|
| Do you have an artificial Joint? <b>Details:</b>                          | Yes | No |
| Do you need to take antibiotics prior to dental treatment? <b>Reason:</b> | Yes | No |
| Do you have any disease or condition not listed above?                    | Yes | No |
| Are you currently under the care of a physician?                          | Yes | No |
| Are you taking any medicine or drugs? <b>List and reason taking:</b>      | Yes | No |

|  |     |    |
|--|-----|----|
| <b>Are you allergic to any medicine or materials?</b> If yes, circle below & list reaction:  | Yes | No |
| Penicillin                      Clindamycin                      Anti-inflammatory                      Narcotics<br>Acrylic                              Metal                                      Latex                                      Sulfa Drugs<br>List Other: |     |    |

|  |     |    |
|--|-----|----|
| Have you ever had a reaction to dental local anesthetic?                                   | Yes | No |
| Have you ever had complications following dental treatment?                                | Yes | No |
| Have you ever been told you were not eligible to be a blood donor?                         | Yes | No |
| Do you use tobacco? Type: cigarettes – pipe- cigar – chewing – dip - snuff                 | Yes | No |
| <b>WOMEN ONLY:</b> Are you Pregnant or is there a chance you could be pregnant? Trimester? | Yes | No |
| Have you ever taken bisphosphonate or osteoporosis medications?                            | Yes | No |
| <b>Would you like whiter teeth?</b>  | Yes | No |
| <b>If you could easily change one problem with your teeth, what would it be?</b>           |     |    |

Dentist Comments:

**Referred By:**

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 information every visit.

|  |                |                |
|--|----------------|----------------|
| <b>Signature of Patient/Legal Guardian (print name if guardian):</b> |                | <b>Date:</b>   |
| Reviewers/date   | Reviewers/date | Reviewers/date |
| Reviewers/date   | Reviewers/date | Reviewers/date |

# WELCOME

We are pleased to welcome you to our practice.  
Please complete this form, and provide any insurance cards.

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Email \_\_\_\_\_ Birthdate \_\_\_\_\_  
Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Notify in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_

## PRIMARY DENTAL INSURANCE

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
ID Number \_\_\_\_\_  
Group Number \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Employer \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
ID Number \_\_\_\_\_  
Group Number \_\_\_\_\_

**I authorize the dentist to release all information necessary to secure payment of insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature \_\_\_\_\_  
Print Name \_\_\_\_\_

Date \_\_\_\_\_

# FINANCIAL POLICY FOR MOON FAMILY & COSMETIC DENTAL

- We accept a variety of dental insurance plans, and assist our patients in filing their claims as part of our service. However, **patients are responsible** for knowing the details of their individual contract, including – benefits, limitations, and yearly maximum coverage.
- Patients with dental insurance must have their benefits verified; and be prepared to pay deductibles and co-insurance at the initial appointment, as well as each subsequent appointment while under treatment. **If the insurance company denies a claim for any reason, this amount will become the patient's responsibility.**
- Patients **NOT** covered by a dental insurance plan are responsible for payment in *full* at the time service. We accept **Visa, MasterCard, Discover, AMEX, and personal checks**. There will be a charge of \$35.00 for any check returned due to insufficient funds, plus any bank fees incurred including bank charge back fees.
- Please be aware our office hours are Monday 7:30 am. to 12:30 pm. - Tuesday thru Thursday 7:30 am. to 5:00 pm. ***A fee of \$75.00 will apply for any no-show/cancellation without two (2) full working days notice.***
- Any account outstanding over 30 days, will incur a finance charge.
- All accounts must be **CURRENT** and in good standing before a new appointment will be scheduled.

**Please sign below acknowledging that you understood the above mentioned policies.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_

# Moon Family & Cosmetic Dental

## Acknowledgement of Receipt of Notice Privacy Practices (Patient Consent Form)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
2. Obtain payment from third party payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice

I acknowledge that I have been informed of your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

**Date** \_\_\_\_\_

**Print Patient Name** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_

**Signature** \_\_\_\_\_