Barr Family Dentistry

TODAY'S DATE: _____

PATIENT INFORMATION

NAME: _____
Last First Middle

Name I prefer to be called: _____ DATE OF BIRTH_____

SOCIAL SECURITY # _____

MAILING ADDRESS: _____
Street City State Zip

PHONE: HOME_____ WORK _____ CELL _____

Whom may we thank for referring you? _____

(Circle One) Married Divorced Widowed Single Minor SEX (Circle One) Male Female

PATIENT EMPLOYMENT

EMPLOYER _____

EMPLOYER ADDRESS _____
Street City State Zip

INSURED OR PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____ SSN # _____
Last First Middle

ADDRESS: _____

PHONE: _____
Home Work Cell

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

CONTACT INFORMATION

NEAREST LOCAL RELATIVE OR FRIEND WE MAY CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP _____ PHONE_____
Home Work Cell

DENTAL INSURANCE

NAME OF PRIMARY DENTAL INSURANCE: _____

GROUP # _____ INSURANCE I D # _____

CUSTOMER SERVICE PHONE # _____

(IF APPLICABLE) NAME OF SECONDARY DENTAL INSURANCE _____

GROUP # _____ INSURANCE I D # _____

CUSTOMER SERVICE PHONE # _____

MEDICAL HISTORY

Are you presently under the care of a physician? Yes___ No___ Date last treated_____

Reason: _____

Physician's Name? _____

How would you describe your general health? (Circle One) Good Fair Poor

Have you been hospitalized or had a major operation(s)? _____

If yes, for what conditions? _____

Are you currently taking any medications, pills, or drugs, including bisphosphonates (such as Aredia or Zometa)? If so, please list each below or provide comprehensive list:

_____

Are you allergic or sensitive to **any** drugs or substances, such as penicillin, latex, codeine, dental anesthetics, or any others? If so, please list

_____

DENTAL HISTORY

Reason for this visit? _____

Name of previous dentist? _____ When was your last cleaning? _____

Are you having pain at this time? _____ Have you had mouth or jaw injuries? _____

When was your last full mouth or panoramic x-ray taken? _____

Is it important to you to keep your teeth? _____ Have you been treated for gum disease? _____

Please circle if you have or had at any time: clicking of the jaw, difficulty in opening & closing, pain from joint, ear or side of face, difficulty chewing

Is there anything about having dental treatment that bothers you? Please explain ---

_____

Consent: The signature of patient or guardian below acknowledges and authorizes the work, fee and completion of all agreed dental services and use of methods appropriate thereto. This agreement and consent shall remain in effect until cancelled by either party. If legal services are obtained to enforce this agreement, patient or guardian shall be responsible for the payment of all dental fees, Dentist's attorney fees, court costs and costs of collection.

SIGNATURE _____ Date_____

Patient, Parent or Guardian

Rev. 6/17

Do you now have or have you ever had any of the following? (Please check (X) box for every question)

	Yes	No		Yes	No
AIDS /ARC/ HIV +	☐	☐	Kidney / Bladder Problems	☐	☐
Hepatitis A , B or C	☐	☐	Stomach Ulcers	☐	☐
Venereal Disease/Herpes/STD	☐	☐	Head or Neck Injuries	☐	☐
Jaundice	☐	☐	Asthma, Emphysema	☐	☐
Liver or Kidney Disease	☐	☐	Arthritis	☐	☐
Artificial Heart Valve	☐	☐	Tuberculosis	☐	☐
Artificial (Prosthetic) Joint	☐	☐	Anemia	☐	☐
Mital Valve Prolapse	☐	☐	Diabetes	☐	☐
Congenital Heart Disease	☐	☐	Thyroid Disease	☐	☐
Rheumatic Heart Disease	☐	☐	Epilepsy / Seizures	☐	☐
Heart Attack /Disease	☐	☐	Swelling of Ankles	☐	☐
Heart Murmur	☐	☐	Allergies	☐	☐
High Blood Pressure	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Headaches	☐	☐
Stroke	☐	☐	Shortness of Breath	☐	☐
Cancer / Tumor History	☐	☐	Sensitivity to Metals	☐	☐
Radiation Treatment	☐	☐	Smoke or Chew Tobacco	☐	☐
			Pregnant or Trying	☐	☐

CONSENT FORM

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherit risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction**: Dental materials and medications may trigger allergic or sensitivity reactions

2. **Long – term numbness (paresthesia)**: Local anesthetic, or its administration, while almost adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness

3. **Muscle or joint tenderness**: Holding one's month open can result in muscle or jaw tenderness, or in a predisposed patient, precipitate a TMJ disorder

4. **Sensitivity in teeth or gums, infection or bleeding**

5. **Swallowing or inhaling small objects**

While we follow procedural guidelines, which most often lead to a clinical success, just like in any pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statement on this page:

_____ Date _____
Patient's Signature

_____ Date _____
Parent's Signature (if minor is the patient)

This signature indicates I have read and understood the "Notice of Privacy Practices" – HIPPA

SIGNATURE _____DATE _____
Patient, Parent or Guardian

I authorize the release of my records to the person(s) listed: _____

Notice of Privacy Practices

Understanding Your Health Record/Information

Each time you visit our office, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your "health record" or "medical record," serves as a:

- Basis for planning your care and treatment
- Means of communication to those who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed actually were provided
- Tool in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged with improving health
- Source of data for facility planning and marketing
- Tool to assess and improve the care we render and the outcomes we achieve

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continue improving the quality and effectiveness of the healthcare and service we provide.

Other Uses or Disclosures

Business associates: Some services in our organization are provided through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. So that your health information is protected, however, we require the business associate to safeguard your information appropriately.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.