BRIAR HILLS
DENTAL

New Dental technology and trends make dental visits more comfortable and enjoyable. Select "YES" or "NO" enabling our oral health care team to be sensitive to your dental needs and concerns. Our goal is to provide a great dental experience for you.

Patient Name_____ Date of Birth_____

Whom may we thank for referring you to our practice (please circle all that apply)?

Another Dental Office (list below)	Facebook	Insurance	Other (list below)
Another patient (list below)	Google Search	Website	

Name of Person or office referring you to our practice: _____

Brushing and Flossing

- Are you currently using a manual toothbrush? YES NO
- Do you feel you could do a better job cleaning between your teeth? YES NO
- Are your teeth Sensitive? YES NO
- Do your gum tissues bleed? YES NO
- Is the prevention of gum disease periodontitis or gingivitis a concern? YES NO

Periodontal Disease

1. Do you have any history of gum disease (periodontitis)? YES NO
2. Have you ever had a deep cleaning (scaling and root planing)? YES NO

Clenching and Grinding

1. Do you grind your teeth and do they show wear? YES NO
2. Are you bothered by persistent headaches or migraine attacks? YES NO

Whitening and cosmetic Improvements

1. Would you like to whiten or brighten your current tooth shade? YES NO
2. Have you used whitening products or procedures? YES NO
3. Have you considered improving your smile with cosmetic dentistry? YES NO

Invisible Braces

1. Would you like to know more about Invisalign? YES NO
2. Have you experienced minor teeth shifting after having worn braces? YES NO

Sedation Dentistry

1. What level of anxiety do you experience with dental visits?
   None at all Some what anxious Highly anxious Extreme Anxiety

Do your fears of dentistry keep you from completing needed dental work? YES NO
Would you like to know more about the various levels of sedation dentistry? YES NO

Last but not least, if you could change something about your smile, what would that be?

_____

_____

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DENTAL

Patient HIPAA Consent Form and Notice of Privacy Practices

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. 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 *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 then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Staying within the "reasonable" guidelines of HIPAA, I give permission for All Care Dental to discuss my dental care and related issues with the following persons, in addition to myself. If none, please state so:

Name: Relationship:

_____

_____

_____

Email and Text Messaging Program Patient Information Form

We provide our patients the option to participate in our online patient communication system.

Some of the system features allow you the ability to:

- **Request Appointments via Email**
- **Confirm Appointments via Email**
- **Receive Text Message Appointment Reminders**
- **Submit Patient Satisfaction Surveys**
- **Refer Your Friends Online**

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email, or by replying to a text message with 'STOP'. Standard text messaging rates apply.

Please Update Your Contact Information

Name:	
Address:	
City:	
State:	
Zip:	
Home Phone:	
Work Phone:	
Cell Phone:	
Email:	
Birthday:	

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for All Care Dental in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Please sign below to indicate that you agree to allow us to use this information in providing your services.

Signature **Date**

All Care Dental
FINANCIAL POLICIES

1. **Payments**: The patient portion, amount not covered by insurance, for all dental services performed must be paid in full at the time of treatment, unless prior arrangements have been approved.

2. **Dental Insurance**: All dental services performed are charged directly to insurance and you are personally responsible for percentages not paid. Our office will assist in preparing and submitting insurance claims and reasonably assist in making collections from insurance companies. We will apply any such insurance payments to your account. However, all insurance payments are **ESTIMATES** only. **We do not guarantee any payments by an insurance company** for dental services rendered by All Care Dental. Any and all amounts not paid by the insurance company for dental services are your responsibility.

3. **Cancellation Policy**: We reserve the right to charge a **$30.00** fee for missed appointments that are not cancelled at least **48 business hours** in advance.

4. **Unpaid Balances**: Please provide a credit card number to transfer any and all unpaid balances that are 90 or more days past due. If there are not prior arrangements made, by signing this agreement you understand and agree that our office will be billing your credit card for the entire balance due on the billing date.

Type of Card: (circle one) Visa Master Card Discover Care Credit
Name on card: _____
Account number: _____
CVV (3 Digit Code on back of card) _____ Exp. Date_____

I have completed the form and have read the above financial and insurance policies and agree to same.

_____ **Date**_____
Patient, parent or guardian's signature

_____
Relationship to patient

Are you covered by Medicaid? Yes No
If yes, I understand neither party can file a claim to Medicaid. _____
(Initials)

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)?
Yes No

ASSIGNMENT OF BENEFITS

I, _____, do hereby authorize my insurance company to directly pay All Care Dental all insurance benefits otherwise payable to me for dental services rendered.

_____ **Date**: _____
Signature

Patient Information

Patient Name:_____ Date:_____
Last First MI (Preferred Name)
Gender: _____ Family Status:_____

Social Security #_____ Birth Date: _____

Phone (Home):_____ (Cell):_____
(Work):_____Ext:_____

Email Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Reason for this visit:_____

Do you now, or have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Cancer/Chemo
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Pain/Congestion
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Headaches
- ☐ Head Injuries
- ☐ Heart Concerns
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ History of HPV
- ☐ Jaw Pain or Noise
- ☐ Limited Opening
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Premedication Needed
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Smoking / Years___
- ☐ Chewing tobacco / Years ___
- ☐ Snoring
- ☐ Substance Abuse
- ☐ Tooth Clenching/Grinding
- ☐ Women; Are you Currently pregnant?
  - ☐ Due date:_____

OTHER:
- ☐ _____

- Are you currently taking any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Are you allergic to any medications? ☐ Yes ☐ No
  If yes, please list: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have a general physician? ☐ Yes ☐ No
  Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:_____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Please read & INITIAL each item below. Your understanding of these items allows us to make your dental care our priority and the business end of things easy for both of us. This document covers you and your dependent children.

_____ **Appointment Guidelines:** I agree to respect the appointment times reserved for me. I understand that this dental team asks for ***at least*** 48 business hours if I need to move or cancel an appointment since late cancellation or failure to show for an appointment causes 'schedule distress' to the dental office. I also understand that I *may* be charged a late cancelation fee, based on the reason, for a missed or failed appointment and that the dental team has the right to refuse to reschedule me if I late cancel too often or miss too many appointments.

_____ **Care to Minor Children:** I understand that the adult who brings a minor child to a dental appointment assumes the financial responsibility for care to that minor. I understand that this office will not get involved in custody, divorced/separation arrangements, etc. Per Nebraska law, a minor is a young person under the age of 19.

_____ **Minor Children in the office:** By law patients ***under*** the age of 19 are considered minors. We require a parent or guardian be with minor children at their dental appointments unless arrangements are made with the Business Manager prior to the appointment. A parent/guardian may be allowed in the exam room if the parent/guardian feels it will be beneficial to the minor child. However, sometimes children behave better without a parent/guardian present.

_____ **Photos/Videos:** I authorize members of this dental team to take photos and/or video of my face, jaws and teeth before, during and after treatment, and that my name or other identifying information will be kept confidential. I understand I will not be compensated for any photo or video taken or used.