TODAY'S DATE_____

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT'S FIRST NAME	INITIAL	LAST NAME	PREFERS TO BE CALLED	
ADDRESS			BIRTHDATE	AGE
CITY	STATE	ZIP	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
HOME PHONE	CELL PHONE	WORK PHONE	SOCIAL SECURITY NUMBER	
EMAIL			DRIVER LICENSE NUMBER	

IF PATIENT IS A MINOR, PLEASE PROVIDE	PARENT/LEGAL GUARDIAN NAME		RELATIONSHIP	
	ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL	
WITH WHOM DOES THE CHILD RESIDE? ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER_____			SOCIAL SECURTY NUMBER	

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON	PHONE NUMBER	RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP
NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE NUMBER	RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS...

WHOM MAY WE THANK FOR REFERRING YOU?	ARE THEY A PATIENT HERE?

OTHER

☐ BUILDING SIGN ☐ MAILER/ADVERTISEMENT ☐ ACCESS DENTAL WEBSITE

☐ INSURANCE COMPANY ☐ YELLOW PAGES ☐ _____

IF YOU HAVE DENTAL INSURANCE, PLEASE PROVIDE

PRIMARY CARRIER		
INSURANCE COMPANY NAME		INSURANCE PHONE
EMPLOYER NAME		EMPLOYER PHONE
INSURED NAME		
BIRTH DATE	RELATIONSHIP TO PATIENT	
INSURED INSURANCE I.D. NUMBER		GROUP NUMBER
INSURED SOCIAL SECURITY		
IF STUDENT, COLLEGE NAME		☐ FULL TIME ☐ PART TIME

SECONDARY CARRIER		
INSURANCE COMPANY NAME		INSURANCE PHONE
EMPLOYER NAME		EMPLOYER PHONE
INSURED NAME		
BIRTH DATE	RELATIONSHIP TO PATIENT	
INSURED INSURANCE I.D. NUMBER		GROUP NUMBER
INSURED SOCIAL SECURITY		
IF STUDENT, COLLEGE NAME		☐ FULL TIME ☐ PART TIME

Barnes Dental Care

DENTAL TREATMENT CONSENT FORM

Providing the highest quality dental care involves keeping you informed so you can make good decisions about your dental health. Please read the following information carefully. It describes the treatment offered in our office. You have a right to ask questions about anything you don't understand. We will be pleased to answer your questions.

- Radiographs(x-rays) of the teeth
- Cleaning of the teeth
- Application of topical fluoride for children
- Application of plastic "sealants" to the grooves of the teeth for children
- Use of local anesthesia to numb the teeth and tissues
- Treatment of diseased or injured teeth with dental restorations (fillings and crowns)
- Replacement of missing teeth with dental prostheses
- Removal (extraction) of one or more teeth
- Root canal Treatment
- Use of sedative drugs to ease apprehensiveness and use of nitrous oxide

I hereby authorize and direct the dentist assisted by other dental auxiliaries of his choice, to perform upon myself or my child (or legal ward for whom I am empowered to consent) the necessary dental treatment or procedures required to maintain my dental health. I certify that I have read and understand this consent form, that I have been given an opportunity to ask questions, and that all questions about the procedure(s) have been answered in a satisfactory manner. I am aware that the practice of dentistry is not an exact science and I acknowledge that no written or oral representations, warranties or guarantees have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand further that I have the right to be provided with answers to questions that may rise during the course of my treatment or that of my child. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

I have been advised that medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination; thus, I have been advised not to operate any vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthetic, medications and drugs that may have been given me for my care. I agree not to drive myself home, and to have a responsible adult accompany me until I am recovered from my medications.

Patient Name (Please Print) _____

Signature of Patient or Legal Guardian_____

Date_____

IF THE PATIENT IS LESS THAN 18 YEARS OF AGE

I, _____, sign this form on behalf of and consent to the treatment explained above to be provided to _____.

Financial and Missed Appointment Policies

In order to enhance communication and promote understanding regarding Barnes Dental Care's financial and missed appointment policy, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with any scheduled appointments. If you have any questions or concerns, please speak to one of the front office staff and they will be happy to help you. Thank you.

INSURANCE AND PATIENT PAYMENT: We are happy to bill any primary and/or secondary insurance carriers as a courtesy to our patients. Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our financial relationship is with you, not your insurance company.

- We do our best to educate you about your insurance. We do everything we can to ESTIMATE what your insurance company may or may not pay on a given procedure. Not all services are covered benefits in all contracts.
- Deductibles, co-pays, write-offs and denials by insurance carriers will affect the amount of money you owe for each procedure processed.
- Copay's will be collected at the time of appointment when possible. If a patient's insurance company does not pay a balance on their account, that balance is due in full and the responsibility of the patient or responsible party on the account.
- ***Payment is expected at the time service is rendered***. For multiple appointment services involving lab fees, 50% of payment will be collected at the time the procedure is started and 50% on the day the service is finished. We accept cash, personal check, Mastercard, Visa and Discover. We accept and will help you apply for Care Credit if you wish to have a long-term payment plan.
- There will be a $35 charge from our bank for any checks returned for insufficient funds. This charge will be passed on to the patient's account.

NO SHOW/MISSED APPOINTMENTS: We understand everyone has a busy schedule and emergencies occur. We request a notice of 48 hours for cancellation of appointments. If we do not receive notice of cancellation of an appointment, a fee of $25 may be added to your account. With the hope of creating an efficient practice for ALL patients in this dental practice, more than 2 missed appointments, ***PER FAMILY***, without notice is grounds for dismissal from the practice.

DATE: _____ PATIENT NAME _____

PATIENT SIGNATURE: _____

(IF PATIENT IS A MINOR) GUARDIAN SIGNATURE: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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 status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ___ _____

Signature of Privacy Officer