Patient Information

Name____ Nickname_______________

Birth date________________ Sex: M or F

Address ____

City/State/Zip ____

Home phone # ______________________

Cell phone # _______________________ Work phone # ________________

E-Mail address___________________________________

Emergency Contact Name/Relationship _______________________________

Emergency Contact Phone number ___________________________________

Patient Employer____

Patient Social Security # ____

If you are under 18 years of age, person responsible for your account:

Name________________________________ Preferred Contact # _________________________

Address____

City/State/Zip ____

Insurance Information

Subscriber Employer _____________________________________

Subscriber name ____

Subscriber Birth Date _________________

Subscriber SS# ______________________

Insurance Company ______________________________________

Subscriber Insurance ID # ___________________________________

List of Dependents Covered: ____

____

Do you have secondary insurance? Y N If Yes, please complete the information below:

Subscriber name ____

Subscriber Birth Date _______________________

Subscriber SS# ___________________________

Insurance Company ______________________________________

Subscriber Insurance ID # ___________________________________

List of Dependents Covered: ___________________________________

I understand that Penterson and Booth D.D.S. will make every effort to collect from my insurance company. I hereby authorize Penterson and Booth D.D.S. to furnish information to insurance carriers concerning my treatment, and I hereby assign to the dentist all payments for dental services rendered to me or my dependents. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by my insurance for services rendered to me or my dependents. I also acknowledge and understand that any costs incurred by Penterson and Booth D.D.S., in the collection of unpaid delinquent accounts will be added to the debt. I authorize that the information on this page is correct to the best of my knowledge.

Signature____Date_________________

Medical History

Patient Name: ______________________________ Date of Birth:______________

Date of last physical _______________Physician Name_______________________________

Are you under a physician's care now? Name?_______________________________ Y N

Have you ever been hospitalized or had a major operation? Discuss with Doctor ___________ Y N

Have you ever had a serious injury to your head or neck? Discuss with Doctor _____________ Y N

Are you on a special diet? Discuss with Doctor ___________________________________ Y N

Do you smoke? Y N Do you use smokeless tobacco? Y N

Do you consume alcohol? Y N

WOMEN: Pregnant _____ Nursing _____ Taking Oral contraceptives _____

Do you have a history of any of the following conditions or diseases: (please circle all that apply)

Congenital heart defect	Diabetes I/II	Immunocompromising condition
Heart surgery	High blood pressure	Cancer
Bacterial endocarditis	Low blood pressure	Chemotherapy
Artificial heart valves	Blood disease	Radiation
Heart attack/ Stroke	Dementia/ Alzheimer's	High Cholesterol
Congestive Heart Failure	Anemia	Psychiatric Care _______________
Angina/ Chest pain	Leukemia	Abnormal bleeding
Difficulty Breathing	Unexplained Weight Loss	Fainting or Dizziness
Hepatitis A, B, C	Drug/ alcohol abuse	Asthma
Artificial Joint Replacement	HIV/AIDS	Seizures
Lung disease	Liver disease	Sinus condition
COPD/ Emphysema	Kidney disease	Hearing loss
Tuberculosis	Thyroid disease	Fever blisters
Renal Dialysis (Days of the week)	GI disease	History of bisphosphonate treatment
M Tues Wed Th F Sat Sun	Hemophilia	Recent Blood Transfusions (Date)_____

Are you taking any medications (prescription, over the counter, vitamins or supplements) Y N

If YES, please list: ____

____

Are you allergic to any of the following: (circle all that apply)

Aspirin Penicillin Latex Metals Local anesthetic Codeine

Are you allergic to any other medications? If YES, please list:_______________________________

Is there any other additional information about your medical history that we need to be aware of such as surgeries or hospitalizations? Y N If yes, please explain_____________________________

Do you wish to talk to the dentist privately about any problems?________________________________

____

AUTHORIZATION

I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

Signature____ Date ________________

Doctor Signature__________________________________

Dental Health History Form

Patient Name: ______________________________ Nickname: _______________

What are your goals in coming to our practice? ______________________________
____

Date of Last Dental Visit: ____________ Date of Last X Rays: _______________

Former Dentist: ____

Are you experiencing any pain now? Y N
If yes, please explain: ____
____

Have you ever been premedicated for dental treatment? Y N
If yes, please explain: ____
____

Have you been anxious about having dental treatment? Y N
If yes, please explain: ____
____

Have you ever had orthodontic treatment? Y N

Have you ever had periodontal treatment? Y N

What concerns do you currently have, if any?

jaw joint pain	unhappy with appearance	tooth sensitivity to hot/cold
clenching/grinding	overbite/underbite	food getting caught
Discoloration	crowding/crooked teeth	difficulty chewing
Missing teeth	old fillings/crowns	bad breath
Spaces between teeth	speech problems	loose teeth
Tooth shape/size	excess gum tissue	dry mouth

Other: ____

Are you interested in learning more about the following?

Teeth whitening	at-home oral hygiene care	hygiene care for infants/toddlers
Dental implants	veneers	periodontal disease prevention
Orthodontic treatment	sleep apnea device	botox

Other: ____

Signature: ______________________________ Date: _______________

PENTERSON AND BOOTH, DDS
APPOINTMENT POLICY

INSURANCE VERIFICATION

With the wide array of different insurance plans, we advise all patients to verify through their current insurance company that the doctors here at Penterson and Booth are In Network Providers to ensure proper insurance coverage. If you plan to change dental insurance plans during open enrollment, or at any time, please verify the insurance you are purchasing is still credentialed as In Network with our providers.

Oftentimes, Out of Network insurance plans still provided benefits to Out of Network providers. We advise all patients enrolled with an insurance plan that is Out of Network to verify if their plan has benefits for such providers. However, in the occurrence that the insurance plan does not provide coverage to an Out of Network provider, the cost of treatment will be the responsibility of the patient.

HYGIENE APPOINTMENTS

Hygiene appointments typically require 60 minutes and patients are seen by appointment only. That appointment time is reserved specifically for you and we make every effort to be on time. We ask that you extend the same courtesy to us and our other patients by keeping this scheduled appointment. We will notify you 1 week in advance with an email or text message to remind you and confirm your scheduled appointment. For any appointments that have not been confirmed, you will receive an email, text message, and/or phone call within 1 to 2 days of your appointment to confirm your arrival on our schedule. If an emergency situation should arise requiring that you change an appointment, please notify us as soon as possible. Our policy is to not charge for missed appointments when we are provided notice within 1 business day before the scheduled appointment. However, if three (3) appointments are missed by members within the same account within a twelve (12) month period, and we have not received proper notice to reschedule, $25 will be charged to the account for each appointment that is canceled the same day it has been scheduled. Penterson and Booth DDS reserves the right to dismiss the family from our practice if scheduling complications persist.

DENTIST APPOINTMENTS

Appointments at or under 1 ½ hours: Doctor and staff time was specifically reserved for you. We require 1 business day notice if you are unable to keep your appointment. Cancellation with failure to notify us with at least 1 business day notice will be considered a broken appointment and you may be charged a fee of $25 at our discretion.

Appointments over 1 ½ hours: Doctor and staff time was specifically reserved for you. To reserve and schedule this appointment, we require a 25% down payment of your estimated copay, if a copay is applicable. We require at least 3 business days notice if you are unable to keep your appointment. If a cancellation is made with at least 3 business days notice, you may request the down payment back if you do not wish to reschedule. If a cancellation is made with less than 3 business days notice, the down payment will still be applied to the rescheduled appointment. Cancellation with failure to notify us with at least 1 business day notice will be considered a broken appointment and you will be charged a fee of $25 at our discretion.

TREATMENT OF MINOR

Minors (under 18 years of age) must be accompanied by a parent (or guardian) for their appointment. If the parent or guardian is unable to attend the appointment, a written note must be provided for consent of treatment. Failure to do so may result in our inability to perform treatment on a minor.

EMERGENCY TREATMENT

If you have a dental emergency during a weekday, we will make every effort to see you that day with minimal impact on our scheduled patients to alleviate your discomfort. In most cases, you will be reappointed for more definitive treatment. As a courtesy to our patients of record, one of the doctors is on call during non-business hours and may be reached by calling 739-1600.

By signing this, I acknowledge that I have read and understand this appointment policy:

Name (Print): ______________________ Signature: ______________________ Date: ________

PENTERSON AND BOOTH, DDS
FINANCIAL POLICY

PAYMENTS

In an effort to keep fees down while providing you with a high level of professional care, we have established the following financial policy:

Self-pay patients: If you do not have insurance, payment in full is due at the time of service unless other arrangements are made in advance. We accept cash, checks and most major credit cards. We can assist you with an in-house payment agreement, or payment plans through Care Credit (GE Financial Network) are available and should be discussed with our financial coordinator.

Insured patients: If you have insurance, you are responsible for your ***estimated*** portion of the charges not covered by insurance at the time of service. The co-payment and/or deductible requested at the time of service, is derived from information provided by your carrier. Your insurance company will not guarantee any payment amount until a claim has been filed. We cannot be held responsible for incorrect information given by your insurance carrier.

After we have received payment from your insurance, the remaining balance must be paid within 30 days of receiving your first statement or pay request. Failure to do so will lead to your account being put into "review status" which can result into account delinquency and the account balance being sent to collections.

If your insurance company pays more than the fee charged, we will send a refund check for the difference to them immediately. If you overpay your full balance, we will either issue you a refund or carry a credit on your account according to your wishes.

INSURED PATIENTS

We participate with several dental insurance companies and as a courtesy to our patients we will process your dental claim for reimbursement, regardless of whether we participate with your carrier or not. Insurance is a contract between you and your insurance company and it is your responsibility to be fully aware of all provisions of your insurance policy. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, and usual & customary charges. In cases with insurance companies with whom we have a participating dentist agreement, we will handle your claims according to our agreement with the insurance company. These companies have multiple plans, and although we may be a participating provider for them, we may not be a participating provider for all of their plans. We strongly urge you to call or visit the insurance company websites to confirm that we are a participating provider for your specific plan. We do not accept Medicaid, Champus, or Worker's Compensation.

DISCOUNTS

A senior citizen discount is available to any retired patient over 65 years of age, whom of which do not have insurance. A 6% discount will be applied to those amounts paid with a credit card. A 10% discount will be applied to those amounts paid with a check or cash.

DELINQUENT ACCOUNTS

An account will be considered delinquent if payment has not been received for 90 days since the date of service, and a letter will be sent to the responsible individual. If you should receive a letter, please contact us immediately to resolve any misunderstanding.

After 120 days has elapsed from the date a statement was processed, and we have not received a reply from you concerning the letter, the account will be classified as delinquent and turned over to our collection agency. In addition to interest on the unpaid balance, all charges including legal fees associated with collecting the unpaid balance will be added to the full amount due.

ACCOUNT SEPARATION

Unless otherwise specified, joint accounts will be created for spouses, families, and/or dependents with a sole proprietor responsible for the account. Once an account history has been established, certain circumstances must be met for individuals to be separated from the original account.

An individual who is no longer a minor (18 years old) may be requested for removal from the account and become their own responsible party.

With any separation request, there can not be any outstanding insurance claims for the individual(s) wanting to be removed. Once all insurance payments have been made for the selected individual(s), at that time we can create a separate account for them to become their own responsible party.

RETURNED CHECK FEE

A charge of $35.00 will be added to your account should your check be returned to us for any reason by your bank.
By signing this, I acknowledge that I have read and understand this financial policy:

Name: ______________________ Signature: ______________________ Date: ________

**** Special note: The practice cannot bill anyone other than the individual who has signed for financial responsibility.**

Appendix 2.3.2 HIPAA Acknowledgment of Receipt of Notice of Privacy Practices

Penterson and Booth DDS

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Patient Name: ______________________________

Signature: ______________________________ Date: ______________

Authorized Representative: ______________________________

Relationship to patient: ______________________________

Authorized Representative Signature: ______________________________

Release of Medical Information

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive info	Release info (Please circle)		Allowed in exam room (Please circle)	
______________________	Y	N	Y	N
______________________	Y	N	Y	N
______________________	Y	N	Y	N

If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from disclosure.

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other ______________________________