

Patient Information

Patient Name: _____ Date: _____
Last First MI

How should we address you: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Home Phone #: _____

Work Phone #: _____ Ext: _____

Cell Phone: _____

Best time to call: _____

E-Mail: _____ How often do you check it? _____

Would you like to receive E-Mail appointment reminders? Yes No

Address: _____
Street Apartment #

_____ City State Zip Code

Dental Health Information

➤ Date of Last Dental Visit: _____ Reason for this visit: _____

➤ Are you having any pain or sensitivity today? Yes No
How long has it been a problem? _____

➤ Are any of your teeth or fillings chipped or broken? Yes No

➤ How do you feel about going to the dentist? _____

➤ Have your past experiences been positive or negative? _____

➤ Why did you leave your last dentist? _____

➤ When was your last full mouth X-ray taken? _____

➤ Do you see the dentist twice a year? Yes No

➤ How would you rank your dental health? 1 2 3 4 5 6 7 8 9 10

➤ What would you like it to be? 1 2 3 4 5 6 7 8 9 10

➤ How do you feel about your teeth? _____

➤ What would you change? _____

➤ How often do you brush your teeth? _____

➤ How many times a week do you floss? _____

➤ What toothpaste do you use? _____

Dental Health Information (Continued)

- Do you use any other oral hygiene products? _____
- Has a dental professional ever shown you how to use a toothbrush and floss? Yes No
- Have you tried any tooth whitening products? Yes No
Which ones? _____
- If there were a simple inexpensive way to whiten your teeth would you be interested? Yes No
- Have you had any treatments for gum disease? Yes No When? _____
- Do you have any family history of gum disease or tooth loss? Yes No
Who? _____
- Do your gums bleed with brushing or flossing? _____
- Have had any loosening or shifting of teeth? Yes No
- Are you interested in avoiding bad breath? Yes No
- Are you aware of the links between your gum health and your overall health? Yes No
- Has anyone ever discussed with you the impact of diet and nutrition on your teeth and health? Yes No
- Do you snack frequently? Yes No On what? _____
- Do you chew gum? Yes No What type? _____
- Do you drink soft drinks, sport drinks, boxed ice tea, or other sugar containing beverages?
 Yes No How much and how often? _____
- Do you smoke? Yes No How much? _____
For how long have you smoked? _____
- Do you use smokeless tobacco products? Yes No How often? _____
- Do you clench or grind your teeth? Yes No
- Do you have migraines, neck aches, or frequent headaches? Yes No
- Would you like to stop your spouse from snoring? Yes No
- Did you have fluoridated water or a fluoride supplement as a child? Yes No
- Do you exercise regularly or participate in any sports? Yes No
- Have you had any of the following, please check those that apply:
 - Clicking, difficulty chewing, or difficulty opening and closing
 - Head, neck, or jaw injury
 - TMJ or TMD
 - Dry Mouth
 - Bad Breath
 - Snoring and/or sleep apnea
 - Frequent Cavities
 - Orthodontic Treatment
 - Oral Surgery
 - Endodontic Therapy (Root Canal)
 - Bite Adjustment and/or splint or bite plane
 - Crowns
 - Tooth Replacements (Implants, Bridges, or Partial Dentures)

Health History

How would you rate your overall health? Excellent Good Fair Poor

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years?

Yes No If yes, please explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Have you ever been told to premedicate with antibiotics prior to any dental work? Yes No

If yes, please explain _____

Do have mitral valve prolapse, heart murmur, or artificial joint? Yes No

If yes, please explain: _____

List any medications, prescription or non-prescription, that you are taking or have taken in the last six months: _____

List any vitamins, supplements, herbs, or natural remedies you are taking or have taken in the last six months: _____

Please list any drug sensitivities, drug allergies, or drug reactions you have had: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jewelry/Metal | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Addiction/ Alcoholism | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sensitivity | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stent/Shunt Placement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis or |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Positive PPD |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Due Date: _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Depression or Mental Illness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Penicillin Disease |
| | <input type="checkbox"/> Jaundice or Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> OTHER: _____ |

> Do you have any health problems that need further clarification? Yes No

> If yes, please explain: _____

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

Patient Name _____

Referral Information

Whom may we thank for referring you to our practice?

- Another patient, friend Another patient, relative
 Dental Office Yellow Pages Internet School Work Other _____

Name of person or office referring you to our practice _____

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: _____

Address: _____

Street

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Consent for Services

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

The doctor(s) and staff of Pursel Dental, P.C. are authorized to treat the Patient named in the Patient Information and to exchange past, present, and future medical information with the patient's other caregivers for the purpose of enhancing and promoting the continuity of care for the patient.

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, check, or credit card at the time services are performed.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full on all accounts, regardless of what my dental benefit plan pays. This office will help prepare my insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. ***However, this dental office cannot render services on the assumption that any charges will be paid by an insurance company.***

I understand my dental benefit program is a contract between me, the employer, and the insurance company; The dentists are not a party to that contract. Not all benefits are covered benefits in all contracts, therefore, I agree to pay for all deductibles, co-payments, noncovered services, and any portion of covered services not paid in full. It is my responsibility to know my contract, and any questions about my contract should be directed to the employer. Any co-payment is expected at the time that services are rendered.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, **and a Monthly cost of rebilling/Account Maintenance charge of \$10.00 per service and date**, unless previously written financial arrangements are satisfied. If any account balance should remain unpaid for an additional 60 days, and the account is referred to a collection agency I agree to pay the costs of collection and that such fees and costs may be added to the account balance.

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 dentist, I agree to pay the reasonable value of said services to said dentist, or his assignee, at the time services are rendered. I further agree that the reasonable value of services shall be as billed unless objected to, by me, in writing, within 30 days.

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.

Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Date: _____ Relationship to Patient: _____

Written Financial Policy

Thank you for choosing Shannon J. & Kevin M. Pursel, DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa or Mastercard, Discover Card

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with check or cash prior to completion of care for treatment plans of \$500 or more.

- Convenient Monthly Payment Plans¹ from CareCredit

- o Allow you to pay over time
- o No annual fees or pre-payment penalties

Please note:

Shannon J. & Kevin M. Pursel, DMD requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

We accept payment in thirds for treatments over \$1000. For plans requiring more than 2 appointments, alternative payment arrangements may be provided.

We also offer in-house financing for treatments over \$500.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

A fee of \$25 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Shannon J. & Kevin M. Pursel, DMD charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹Subject to credit approval

²However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION:

PLEASE READ CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and health care operations.

- TREATMENT means providing, coordination or managing health care and related services by one or more health care providers: an example of this would include cleaning services.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspects of running or practice, such as conducting quality assessment and improvement activities, auditing functions, post-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 16, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices for the office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the Provisions of this notice or for more information about HIPAA call toll free: 1-877-696-6775

Patient Name (print) _____ Signature _____ Date _____