Breckinridge
Dental & Orthodontics

Thank you for choosing our office.

In order to serve you properly, we will require the following information. All information is strictly confidential. (**Please print**)

Patient's Name: _____
Last First MI

Social Security: _____ Sex: (M) (F) Date of Birth:_____
MM/DD/YYYY

Reason for today's visit? _____

Please circle who you would like to see: **Dentist** **Orthodontist** **Both**

How did you hear about our office? _____

Responsible Party Information:

Name: _____ Marital Status: _____
Last First MI

Address: _____ City: _____State:_____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Emergency Phone Number: _____Email:_____

Date of Birth: _____ Relationship to Patient: _____
MM/DD/YYYY

Insurance Information:

Name of primary account holder: _____

Name of insurance company: _____

Subscriber/Member I.D.:_____ D.O.B. of primary acct. holder: _____

Insurance phone number: _____ Group number: _____

Name of secondary insurance account holder (if applicable): _____

Name of insurance company: _____

Subscriber/Member I.D.:_____ D.O.B. of secondary acct. holder: _____

Insurance phone number: _____ Group number: _____

Dental History:

When was the patient's last visit to the dentist? _____

Has the patient ever seen an Orthodontist? (Yes) (No) If yes, when was last visit? _____

Is the patient interested in a free orthodontic consult? (Yes) (No)

When was the patient's last cleaning? _____

Is the patient having any sensitivity towards hot/cold food or drinks? (Yes) (No)

Is the patient in Pain? (Yes) (No)

Medical History:

Are you seeing a physician? (Yes) (No)

Name and address of physician(s): _____

What medication is the patient currently taking? _____

(Females) Are you currently pregnant? (Yes) (No) If yes, how many months pregnant? _____

Circle any of the following of which you had or have at present:

Heart Disease	Scarlet Fever	Hay Fever
High Blood Pressure	Anemia Nervousness	HIV/AIDS
Blood Disease	Kidney Problems	Thyroid Disease
Rheumatic Fever	Epilepsy/Seizures	Arthritis
Heart Murmur	Ulcers	Cancer
High Cholesterol	Heart/Pacemaker	Sickle Cell Disease
Glaucoma	Diabetes	Tuberculosis
Joint replacement	Jaw joint pain/TMD	Asthma

Other: _____

Circle any of the following medications you are allergic to:

Local Anesthetic/Lidocaine	Sulfa Drugs	Codeine
Penicillin	Aspirin	Latex

Other: _____

To the best of my knowledge, all of the previous answers are correct. I will notify the office if there are any changes to my health or changes in my medication consumption at the next appointment.

Signature: _____ Name: _____

Date: _____

MM/DD/YYYY

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HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____
MM/DD/YYYY

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FINANCIAL AGREEMENT

Payment is due at the time of service unless prior arrangements have been made.
It is our policy to have a definite agreement between you the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment please ask our front desk for an approximate cost **prior** to treatment. For convenience, we accept cash, check, VISA, MasterCard, Discover, and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the office manager must be paid for at the time of service.

PATIENTS NOT COVERED BY DENTAL INSURANCE
Payment is expected when services are rendered. If major dental work is required, it is understood that at least half of the balance will be paid when treatment is started. The remaining balance is due when the treatment is completed. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or **verified** dental insurance must be paid for at the time of service.

PATIENTS COVERED BY DENTAL INSURANCE
If you have dental insurance we will be happy to complete the necessary forms for your claim as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, the entire balance becomes the patient's responsibility. A refund will be given when the benefits have been received from the insurance company. The office cannot render services in the assumption your charges will be paid by your insurance company. Any balance exceeding 60 days may have a 10% per annum service charge on the unpaid balance. We charge a $10 billing charge for any statement sent 90 days after charges were incurred.
In consideration for the professional service rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all cost and reasonable attorney fees if the suit be instituted here under. If your account is turned over to a collection agency and a collection fee of 40% of the account balance will be added and must paid by the patient. I grant my permission to you to telephone me at home or work to discuss matters related to this form. After 2 consecutive missed appointments, it is our policy not to reschedule you for any further appointments. There is a $25.00 charge for all returned checks for which the balance of the check and the return check fee will be paid for in cash or money order only. We require a 24-hour notice to reschedule or cancel an appointment. This will enable us to serve other patients that may need emergency dental care. There is a $ 35 charge for a missed appointment if notice is not given.

I have read and understand the above financial and office policy agreement. I have read and understand the Notice of Privacy Practice (HIPAA) posted in this office and will receive a copy of these upon my request.

_____ _____
Patient name *Date*

_____ _____
Patient/Legal Guardian Signature *Date*