BASS DENTISTRY

PATIENT INFORMATION

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Name that you prefer to be called: _____

Sex: ☐M ☐F Date of Birth: _____ Social Security Number: _____

Address: _____ City _____State _____ Zip _____

Phone number: (h) _____ (c)_____ (w) _____

Email address: _____

Preferred method of communication: ☐Phone call ☐Text message ☐Email

Marital status: ☐M ☐S ☐W ☐D Number of children: _____ Children's ages _____

Are you presently employed? ☐Yes ☐No ☐Full time ☐Part time ☐Unemployed ☐Disabled ☐Retired

Occupation: _____ Employer: _____

What is the reason for seeing us today? _____

Who may we thank for referring you? _____

What can we do to ensure your experience with us is a pleasant one? _____

What was the reason you stopped seeing your previous dentist? _____

SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ patient ☐ the insurance policy holder
Employer Name:_____ Phone:_____
Address: _____ City _____State _____ Zip _____
Occupation: _____

SPOUSE OR SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ patient's spouse ☐ the insurance policy holder
First Name_____ Middle Name_____ Last Name _____
Name that you prefer to be called: _____
Sex: ☐M ☐F Date of Birth: _____ Social Security Number: _____
Address: _____ City _____State _____ Zip _____
Phone number: (h) _____ (c)_____ (w) _____
Email address: _____

DOCTOR HISTORY

Primary Care or Referring Physician (Name & Phone): _____
Previous Dentist (Name & Phone): _____

EMERGENCY CONTACTS

Emergency Contact (Name & Phone): _____
Emergency Contact (Name & Phone): _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Name: _____ Phone #: _____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security #:_____ Subscriber Date of Birth: _____
Group / Policy Number: _____
Is this an employer or union policy? _____

Secondary Dental Insurance

Insurance Company Name: _____ Phone #_____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security #:_____ Subscriber Date of Birth: _____
Group / Policy Number: _____
Is this an employer or union policy? _____

Primary Medical Insurance

Insurance Company Name: _____ Phone #_____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security #:_____ Subscriber Date of Birth: _____
Group / Policy Number: _____
Do you have secondary medical insurance? _____

MEDICAL HISTORY

Patient's Name: _____ Today's Date: _____

Date of Last Physical: _____ Weight: _____ Height: _____

Please check if you have ever had any of the following:

☐ Allergies (seasonal)
☐ Allergies to latex
☐ Allergies to medications (list below)
☐ Acid Reflux/ GERD
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Angina / Chest pain
☐ Anxiety
☐ Blood disease
☐ Breast Implants
☐ Breathing problems
☐ Bleeding disorder
☐ Chronic bronchitis
☐ Chronic fatigue
☐ Cancer or tumors
☐ Circulation problems
☐ Congenital heart condition
☐ Diabetes
☐ Drug / Alcohol abuse
☐ Depression
☐ Dizziness
☐ Earaches
☐ Emphysema
☐ Epilepsy / seizures
☐ Eating disorder
☐ Fainting / dizzy spells
☐ Glaucoma
☐ Gall bladder problems
☐ Herpes
☐ Heart disease
☐ Heart Valve replacement
☐ Head / neck trauma
☐ Heart attack
☐ Healing problems
☐ Headaches
☐ Heart murmur
☐ Hepatitis
☐ High blood pressure
☐ High cholesterol
☐ HIV / AIDS
☐ Immune system disorder
☐ Infective endocarditis
☐ Jaundice
☐ Joint replacement
☐ Kidney disease
☐ Joint disease
☐ Liver disease
☐ Lupus
☐ Mitral valve prolapse
☐ Neurological problems
☐ Nervous disorders
☐ Neurological disorder
☐ Osteoarthritis
☐ Osteoporosis
☐ Persistent cough
☐ Panic attacks
☐ Prosthetic joint
☐ Psychiatric care
☐ Psychological disorders
☐ Pacemaker
☐ Radiation therapy
☐ Ringing in ears (Tinnitus)
☐ Rheumatic fever
☐ Rheumatoid arthritis
☐ Shortness of breath
☐ Sinus problems
☐ STD
☐ Sleep apnea
☐ Stomach problems
☐ Stroke
☐ Tuberculosis
☐ Thyroid disorder
☐ Ulcers
☐Other
_____

Do you have any allergies to medications?

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Tetracycline ☐ Penicillin ☐ Sulfa

☐ Other allergies to medications (please list): _____

If you checked any of the above or have other medical conditions, please explain: _____

_____

_____

_____

Number of alcoholic drinks per week: _____

Do you or have you ever smoked or used chewing tobacco? ☐ YES ☐NO

If yes, how much and for how long? _____

Have you had a **heart attack or heart surgery (bypass/stent)** in the last 6 months? ☐**Yes** ☐**No**

Have you ever taken "bisphosphonates" (Fosamax, Actonel, Aredia, or Pamidronate?) ☐**Yes** ☐**No**

Do you need to be pre-medicated with antibiotics for dental treatment? ☐**Yes** ☐**No**

<u>Women Only:</u>

Any chance you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Please list ALL medications that you are currently taking:

☐ I take no medications at this time

Medication	How often	For What	Amount taken	Doctor

I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Patient Name: _____ Today's Date: _____

Patient Signature: _____

DENTAL HISTORY

Patient's Name: _____ Date: _____ Date of last dental exam:_____
Date of last cleaning:_____ How often do you brush? _____ How often do you floss? _____

Please check all that apply to you:

☐ Bleeding gums	☐ Tooth removal	☐ Food gets stuck	☐ Accident in past	☐ Pain when chewing
☐ Tooth decay	☐ Braces	☐ Loose teeth	☐ Gum surgery	☐ Jaw surgery
☐ Broken teeth	☐ Sensitive teeth	☐ Toothache	☐ Bad breath	☐ Hot / cold sensitive
☐ Wear of teeth	☐ Crowding of teeth	☐ Dry mouth	☐ Other: _____	

Are you happy with the way your teeth look? ☐YES ☐NO If not, why? _____

Are you dissatisfied with any of the following?

☐ Shape of teeth	☐ Crowding	☐ Silver fillings	☐ Color	☐ Length
☐ Spacing	☐ Old fillings	☐ Misalignment	☐ "Gummy" smile	☐ Old crowns
☐ Bad bite	☐ Other			

Do you have any sores / spots in mouth that haven't healed for more than 2 weeks? ☐ Yes ☐ No

Please check all that apply to you:

☐ TMJ problems	☐ Jaw clicking	☐ Pain in jaw	☐ Grinding teeth
☐ Pain in facial area	☐ Numbness in fingers	☐ Tingling in fingers	☐ Dizziness (vertigo)
☐ Ringing in ears	☐ Numbness in face	☐ Neck or back pain	☐ Jaw clenching
☐ Tightness in face	☐ Wear a night guard	☐ History of jaw lock	☐ Difficulty chewing
☐ Difficulty opening mouth	☐ Pain behind eyes	☐ Trigeminal neuralgia	☐ Bells Palsy

Headache history: please check all that apply to you

Location of pain: ☐ Front of head / forehead ☐ Side of head ☐ Back of head
Intensity of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10(extreme pain)

Do you suffer from morning headaches?	☐ Yes	☐ No	☐ Sometimes
Do headaches wake you up from sleep?	☐ Yes	☐ No	☐ Sometimes
Do you have nausea with headaches?	☐ Yes	☐ No	☐ Sometimes

Frequency of headaches: ☐ Constant ☐ Once/day ☐ Once every few days ☐ Once/week

Sleep Apnea Assessment: please check all that apply to you

Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No If yes, when? _____
Diagnosing physician: _____ Name of sleep center? _____
Please check all that apply to you:

☐ Snoring	☐ Gastro-esophageal reflux	☐ Insomnia
☐ Gasping for air during sleep	☐ Feel tired in morning	☐ Poor concentration
☐ Poor memory	☐ Difficulty breathing through nose	☐ Fatigue
☐ Trouble sleeping	☐ Nervousness	☐ Excessive daytime sleepiness
☐ Irritability	☐ Anxiety / depression	☐ Morning stiffness

Have you ever used a CPAP device and could not tolerate it? ☐ Yes ☐ No
If you were not able to tolerate the CPAP, why? _____

FACTS ABOUT YOUR DENTAL INSURANCE

We thank you for choosing us as your dental health provider. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

Navigating through the constantly changing world of dental insurance is a highly complex endeavor. We put together this information because we want you to understand the challenging world of dental insurance. We take great pride in being your healthcare advocate and providing you with the highest level of ethical, quality care for your entire family. Our greatest priority is to make close friendships with our patients and to deliver incredible dental experiences based on trust and experience.

We also understand how important it is to make dentistry comfortably affordable. Our goal is to maximize your insurance benefits and to minimize your out of pocket expenses, and we work diligently on your behalf to maximize insurance coverage. Too often, we find ourselves in an impossible position trying to predict what insurance coverage will be without being given a full disclosure from your insurance company. Despite our best efforts, often times, the insurance companies do not provide us with adequate or correct information about your benefits, which affects our ability to estimate the patient financial responsibility.

Insurance companies have numerous coverage loopholes and they frequently change their criteria for denying coverage, delaying or declining payments, and “downgrading” restorations to lower quality ones – at a great detriment to patient care. For example, many insurance plans will only pay for amalgam (silver) fillings, or crowns that are made of metal, rather than porcelain or zirconia.

Please know that we feel your frustration, and truly want to help – yet we are as helpless as you are! We are powerless in being able to dictate what the insurance companies decide and whether to provide the proper benefits to our patients.

We greatly value our relationship with our patients and will continue to strive to do our best to care for you and your family in every possible way – we want to be your dentist for life. Please do not hesitate to reach out to us if you have any questions pertaining to your dental insurance coverage or billing.

OUR COMMITMENT TO YOU:

- We are, and always will be, your healthcare advocates and are fully committed about educating you in matters of insurance coverage and helping you maximize your dental benefits
- We will continue to fight on your behalf to assist you in receiving the best possible care for you and your family
- We will make every attempt to verify your benefits and to obtain an accurate breakdown verification
- We will process all the billing information as required per your insurance company, including providing any required information, such as narratives, x-rays, photos, and records.
- We will inform you of the cost of your treatment and provide you with any information that you need if you would like to accurately discuss the treatment coverage with your insurance company

If you have any questions, please don’t hesitate to call us at 980.500.3999 or contact your insurance company for detailed explanation of your benefits.

FINANCIAL and OFFICE POLICY

Please remember that insurance policies are a contract between the patient and their insurance carrier. After receiving care at our office, we will gladly submit dental insurance claims on your behalf. However, filing your dental claim is not a guarantee of payment and it is your responsibility to be familiar with your specific plan benefits. Most dental insurance plans have exclusions and limitations, which will affect your out of pocket expense. We cannot guarantee coverage as quoted in our office estimates and exact insurance payments are not known until the claims are processed by your insurance company. A few weeks after your claim for services has been processed, you will receive an explanation of benefits (EOB) from your insurance company. Once you receive your EOB, if you have any questions or concerns, please call our office and we will gladly answer any questions that you may have.

_____ All copayments, co-insurance, and/or deductibles are dictated by your insurance plan. Any co-payments, co-insurance, and/or deductibles are due in full at the time of treatment. If payment from a dental insurance company is not received within 90 days of the date of service, the entire balance is due and payable by you, at which time you may dispute the claim and be reimbursed directly by the insurance company.

_____ Before treatment is started, you will receive a treatment plan, detailing any copayments, co-insurance, and/or deductibles that they will be responsible for. The treatment plan is only an ESTIMATE, and can change based on your conditions that are discovered during treatment. This treatment plan not a guarantee of payment. Any charges not paid by an insurance becomes patient responsibility. A prior pre-authorization of services does not guarantee payment from an insurance carrier.

_____ Payment for services will always be due at the time of service. For any unpaid balances by insurances, the patient will need to contact our office within 30 days to make full payment. Interest will incur if a balance remains unpaid after 60 days.

_____ Please give notice of cancellation or rescheduling your appointment 48 hours in advance. If you fail to keep your appointments without notifying us in advance, a $50 missed appointment fee will apply.

_____ I understand that any dishonored checks will be assessed a statutory handling and collection fee of $50 plus any bank related charges. I also understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of this dental office.

_____ I acknowledge that I have read, understand and agree to the terms of the Bass Dentistry Dental Insurance and Financial Arrangement Policies. I acknowledge that I have been informed of the treatment plan and estimated fees. I agree that I am financially responsible for all co-insurance, deductibles and non-covered services, and any residual balances from claims processed by my insurance carrier. I understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of Bass Dentistry Dental.

ASSIGNMENT OF BENEFITS

_____I understand that services rendered to me are my financial responsibility and that the provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to Bass Dentistry and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

_____I have been given the opportunity to pay my estimated deductible, copayments, and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be

paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

_____I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

_____I also understand that should my insurance company send payment to me, I will forward the payment to Bass Dentistry within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

_____A photocopy of this Assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. I further authorize a release of all my patient information should such a complaint be necessitated.

Patient Name: _____ Today's Date: _____
Parent / Guardian Name (if patient is a minor): _____
Patient or Parent / Guardian Signature: _____

CONSENT TO TREATMENT

Helping you maintain optimum oral health is our biggest priority. The benefits of a happy, healthy smile are immeasurable, and it is our goal to work with you to reach and maintain maximum oral and overall health that will last a lifetime. In order to provide you with the best care available, there are some guidelines that have been established. Please read the information below, and we would be happy to discuss any of the policies with you.

We will present you with a treatment plan estimate so that you can understand the estimated costs of recommended treatment prior to its start. The treatment plan estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to our practice when the estimate is furnished. Dental needs may be unpredictable, and as treatment progresses, the doctor may determine that your condition necessitates a different approach or additional treatment may be necessary based on your dental conditions. Changes to treatment may be determined after treatment is started. When this occurs, be advised that patient financial responsibility may change and you will be responsible for any additional fees that may be incurred during the course of treatment.

The most common change in treatment plan is needing root canal therapy (RCT) following routine restorative procedures. The need for root canal treatment may occur following any restorative procedure (fillings, crowns, inlays, onlays, veneers. We are not always able to determine the need for RCT prior to, or at the time of treatment, and this need may occur at any point following the restorative treatment (possibly days, weeks, months, or years later).

_____I authorize and give consent to the doctor and the staff to administer treatment, including, but not limited to local anesthesia, analgesia, x-rays, photographs and any other treatment that in their judgment, may be necessary for dental health. I understand that the use of medications, anesthetics and some procedures may embody a certain amount of risk. This may include allergic reactions and/or other reactions/sensitivities. If I am female using oral contraceptives, I understand that antibiotics or other medications may interfere with the effectiveness of oral contraceptives. It is my responsibility to inform the doctor of any medical or dental conditions or concerns I may have.

_____I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or courses of treatment.

_____I authorize the provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) listed in the "treatment plan". I also authorize and give my consent for these individuals to administer any necessary medicine and to perform any compulsory life-saving procedures.

_____I understand and agree that all photographs are the sole property of Bass Dentistry.

_____I hereby authorize all previously treating physicians to release my medical records to Bass Dentistry upon request.

_____I acknowledge that I have received a Notice of Privacy that was provided to me by Bass Dentistry. I hereby authorize Bass Dentistry to release any information necessary to process my dental insurance claims. I further authorize a release of information if necessary, to refer my case to a specialist.

_____I understand that no guarantee or assurance has been given that the proposed treatment will be curative and / or successful to my complete satisfaction; I agree to cooperate completely with the recommendations of the doctor while I am under her/ his care, realizing that any lack of same could result in less than optimum results. I certify that I have had an opportunity to read and fully understand the terms and words within the above, and consent to the operation and explanation referred to or made. I have been encouraged to ask questions and have had them answered to my satisfaction. I hereby confirm that I understand this form and the information contained therein. I understand and speak English clearly.

Patient Name: _____ Today's Date: _____

Patient Signature: _____

DENTAL, HEALTH, and MEDICAL INFORMATION RELEASE FORM

I hereby authorize Bass Dentistry and its affiliates, its employees and agents to release my personal health information to

_____.

Records may include:

-All medical and dental records, meaning every page in my record, including but not limited to: office notes, fact sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinical records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
-All billing records including statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand that any personal health information or other information released to the person or organization identified above may be subject to a re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and will remain in effect until terminated by me in writing.

I understand that I have a right to revoke this authorization by providing written notice to Bass Dentistry Dental. I also understand that I have a right to a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign.

Patient Name: _____ Today’s Date: _____

Patient Signature: _____

Please list the full names of any individuals (family, friends, caretakers, etc.) that you would like to have access to your records. The persons listed below will also be able to call our office and discuss your treatment.

_____
_____

_____
_____

_____
_____

BASS DENTISTRY NOTICE OF PRIVACY PRACTICES

Bass Dentistry and our team are required to maintain the privacy and confidentiality of our patients' protected health information. We understand that your medical and dental information is personal and we are committed to protecting it. We are legally bound to provide our patients with notice of our legal duties and privacy practices with respect to patients' protected health information. We create a record of the care and services you receive at our office. This record is necessary to provide you with quality dental care and to comply with legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI). We have a Legal Duty to:

- Keep your personal health information private and to
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
- Follow the terms of the current notice
- Notify you in a timely manner of an accidental disclosure of your private health information

We Have the Right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: When we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR PRIVATE HEALTH INFORMATION

The following describes different ways that we use and disclose your private health information. Not every use or disclosure is listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical or dental information for any purpose not listed below with- out your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

- For Treatment: We may use your PHI to provide you with dental treatment or services. We may disclose medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
- For Payment: We may use and disclose your PHI for payment purposes. A bill may be sent to you, a third-party payer or to a collection agency. The information on or accompanying the bill may include your treatment information.
- We will not sell or use your personal health information for marketing or fundraising purposes without first obtaining your signed authorization.
- We are required to inform you if there are any financial conflicts of interest with us and the products or services utilized by us.
- If you pay for your dental treatment and request that we not disclose the procedure to your insurance company we must comply with your request as long as you pay in full for the procedure in a timely manner.
- You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, we are required to send them as directed and in a timely manner.
- You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

PATIENT ACKNOWLEDGEMENT

I have had an opportunity to read and consider the contents of this Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I understand that I may request in writing that you restrict how my private health information is used or disclosed

PATIENT/GUARDIAN NAME:(PRINT)_____

RELATIONSHIP TO PATIENT:_____

SIGNATURE: _____ DATE: _____