Boyd Family Dentistry

Patient Information

(Please Print)

Patient Name _____ Date of Birth _____ Male/Female

If minor, Parents Name _____ Home Phone _____

Mailing Address _____ Alternate Phone _____

City _____ State _____ Zip Code _____ Email _____

Driver's License/ID # _____ State Issued _____ Expires _____

Employer _____ Phone _____

Dental Insurance Carrier _____ Phone _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Social Security # _____ Group # _____

Patient Primary Physicians _____ Phone _____

Is patient being treated for any medical condition: List _____

Current Medications _____

EMERGENCY Contact Name _____ Phone _____

Name of Pharmacy _____ **Location** _____

Phone _____

Primary reason for your visit today: _____

How did you hear about us? _____

Patient/ Legal Guardian Signature _____ **Date** _____

Health History

Patient Name _____ Date of Birth _____ Male/Female

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION.

1. Are you in good health? …… Y N
2. Has there been any change in your general health in the past year? …… Y N
3. Date of last check up by Physician: _____ Y N
4. Are you currently under a Physician's care? …… Y N

   If so what for? _____

   Treating Physician's name _____ Phone _____
5. Have you ever had any serious illness, operations, or hospitalizations? …….. Y N

   If so, describe and give approximate dates: _____

   _____

   _____
6. Have you ever had intravenous sedation or general anesthesia? ……..... Y N

   Were there any adverse effects? …….. Y N
7. Do you generally tolerate dental treatment well? ……..... Y N
8. **DO YOU HAVE OR HAVE YOU EVER HAD**:

   a. Heart disease that was defected at birth? ……..... Y N

   b. Rheumatic fever or Rheumatic heart disease? ……Y N

   c. Cardiovascular disease (chest pains, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpations, heart surgery, angioplasty, pacemaker)? …….. Y N

   d. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? ……..... Y N

   e. Neurologic disorders (seizures, epilepsy, fainting, dizziness, nervous disorder)? …… Y N

   f. Blood disease (bleeding disorder, anemia, blood transfusions, do you bruise easily)? …. Y N

   g. Liver disease (jaundice, hepatitis)? ……..... Y N

   h. Diabetes? ……..... Y N

   i. Thyroid disease (hypothyroidism, tumor)? ……..... Y N

   j. Kidney disease? ……..... Y N

   k. Arthritis? If so, which joints? _____

l. Stomach ulcers or intestinal problems? ……..... Y N

m. Glaucoma? ……..... Y N

n. Frequent or recurrent mouth sores? ……..... ….. Y N

o. Implants/artificial joints anywhere in your body? (heart valve, hip, knee)? …..... Y N

p. Radiation (x-ray treatment for cancer) on head and neck region? ……. Y N

q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? …… Y N

r. Sinus or nasal problems? ……... Y N

s. Any disease, drug, transplant operation or HIV that has depressed you immune system? Y N

9. **ARE YOU TAKING OR USING ANY OF THE FOLLOWING**?

a. Antibiotics? ……Y N

b. Anticoagulants (Blood thinners)? …….. Y N

c. Thyroid medications? …… Y N

d. Antihistamines, Decongestants? …… Y N

e. High blood pressure or heart? …… Y N

f. Steroids? ……. Y N

g. Tranquilizers, Antidepressants? ……. Y N

h. Stomach or GI Medications (antacids, etc.)? ……. Y N

i. Cholesterol reducing drugs? ……. Y N

j. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs opioids, or other pain relievers? Y N

k. Weight reduction pills or diet aids (over the counter or “natural” products)? …….. Y N

l. Vitamins natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? Y N

m. Marijuana, cocaine, or other “recreational” drugs? …….. Y N

n. Any other regular medications, pills, supplements or drugs? ……... Y N

Boyd Family Dentistry

PLEASE LIST ALL CURRENT MEDICATIONS HERE:

_____

_____

_____

10. Are you allergic to or had a bad reaction from:

    a. Local anesthetic (Novocain like drugs)? Y N
    b. Penicillin, Amoxicillin, Cephalosporin? Y N
    c. Other antibiotics? ..... Y N
    d. Barbiturates, Sedatives?..... Y N
    e. Aspirin, Ibuprofen, NSAIDS, or other pain medicines? ..... Y N
    f. Codeine or other narcotics or opioids? Y N
    g. Latex? ..... Y N
    h. Other allergies or reactions? ..... Y N

    If so, please list: _____

11. Do you have hay fever, frequent skin rashes, etc? ..... Y N
12. Do you use alcohol? How much per day? _____ Y N
13. Do you smoke?..... Y N

    What product and how much per day? _____ For how long? _____

14. Do you spit tobacco? ..... For how long? _____
15. Are you, or have you been, in a drug or alcohol recovery program? ..... Y N
16. Do you have any other disease, conditions or problems not listed that you think the doctor should know about? ..... Y N
17. Do you wish to talk to the doctor privately about anything? ..... Y N
18. Any additional comment? _____
19. **WOMEN**

    A. Are you taking birth control? ..... Y N
    B. Are you pregnant, trying to become pregnant or <u>any chance</u> you might be pregnant? Y N
    C. Are you BREAST FEEDING? ..... Y N
    D. Are you taking hormonal replacements? ..... Y N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____

_____

Signature of Person Completing Health Questionnaire Date

_____

Signature of Person Reviewing Health Questionnaire Date

Informed Consent For Dental Prophylaxis

Patient: _____

It has been recommended by your general dentist at Boyd Family Dentistry that you receive a prophylaxis (cleaning).
Dental Cleanings are essential for maintaining health in your mouth. Overtime, bacteria, food debris, and calcified (hardened) material can accumulate on your teeth that your toothbrush can't remove. Some people get this accumulation much quicker and in greater amounts than others. It may be recommended that you receive professional cleanings every 3, 6, or 12 months depending on your level of need.

At the appointment:

1. Removal of plaque and calculus with metal instruments and/or ultra-sonic scalers
2. Coronal polishing
3. Flossing of teeth
4. Taking radiographs (X-Rays)
5. Application of fluoride
6. Provide Oral Hygiene Instructions

Benefits:
Remove Plaque and calculus that can aid in development of cavities or gum disease
Instruct Patient in proper homecare
Prevent pre-mature loss of teeth from gum disease
Make teeth more resistant to cavities with the application of fluoride

Risks:
Teeth may become sensitive to air, hot, cold, stimuli
TMJ (Jaw Joint) may become tender due to prolonged mouth opening
Tenderness may be present in the gums for a short time after a cleaning

I acknowledge that all the procedure has been explained to me and I give my consent for treatment.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Dental Treatment Consent Form

Patient Name: _____ **BP:** _____
Birthdate: _____ **Pulse:** _____

*Please **read** and **initial** the items checked below.*

_____ **1.WORK TO BE DONE**
I understand that I am having the following work done: Fillings _____ Bridges _____ Crowns _____ Root Canals _____
Extractions _____ Impacted teeth removed _____ General Anesthesia _____ Other _____

_____ **2. DRUGS AND MEDICATIONS**
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____ **3. CHANGES IN TREATMENT PLAN**
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

_____ **4. REMOVAL OF TEETH**
Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

_____ **5. CROWN, BRIDGES AND CAPS**
I authorize the Dentist to perform crown or bridge procedures on the following teeth _____**.** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.

_____ **6. DENTURES, COMPLETE OR PARTIAL**
I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the 'teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

_____ 7. **ENDODONTIC TREATMENT (ROOT CANAL)**
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment.

_____ 8. **PERIODONTAL LOSS** (TISSUE & BONE)
I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that dental practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding my treatment, and all questions have been answered to my satisfaction.

_____

Signature of Patient, Parent, Guardian or Personal Representative Date

Patient Information Release Form

I, _____, give Boyd Family Dentistry permission to discuss any future treatment or future payments with

NAME	RELATIONSHIP	PHONE NUMBER

Print Name Date

Signature Date

Boyd Family Dentistry

PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FORM FOR PATIENTS

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but it is not mandatory for me to sign in order to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certificates

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice to Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bonded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

DOB _____

Boyd Family Dentistry

Patient Name _____

Patient Signature _____

Relationship to Patient _____

Date _____

Notice to Insurance Patients

I am responsible for my balance if any of the following occurs:

1. The treatment goes over my yearly maximum
2. My insurance company denies any treatment
3. I am not eligible for insurance
4. I prevent or delay payment by not complying with requests for insurance forms or signatures
5. I do not complete my treatment and it results in non-payment by the insurance company
6. Lab costs are incurred due to missing appointments
7. I receive my insurance check and do not send it to your office
8. Due to the fact that some insurance companies downgrade services, our office collects 10-30% more of your coinsurance. Once we receive payment from your insurance company, if they have not downgraded services you may be due a credit. In that case you will be notified and given a choice of leaving the credit on your account for future treatment or a refund check, which will be issued within 30 days of posting

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorize release of any this information relating to this claim.

I have read and understand my obligations in acceptance of my dental insurance as payment.

Patient, Parents or Guardian Signature Date

Patient Name (Please Print)

Written Financial Policy

Thank you for choosing Boyd Family Dentistry. 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, Mastercard, American Express, or Discover

  We offer a 30% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion care for treatment plans of $750 or more.

- We offer a 25% courtesy accounting for patients who pay for their treatment with Visa, Mastercard, American Express, or Discover.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allows you to pay over time
  - No annual fees or pre-payment penalties

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[1] **Subject to credit approval**

Please Note:

Boyd Family Dentistry requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less than the non-discounted cost of care received.[2]

For plans requiring more than 4 appointments, alternative payment arrangements may be provided.

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

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

Boyd Family Dentistry charges $45 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) Date

[2] **However, if we do not received 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**