PINEBROOK DENTAL CENTER
A BayView™ Dental Affiliate

Patient Information

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name: _____
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred by: _____

Previous dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Spouse Name: _____

Spouse Cell: _____

Spouse Phone: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

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2022 Pinebrook Dental Health History

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

PINEBROOK DENTAL CENTER
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Patient Smile Evaluation

Patient Name: _____ **Date:** _____

Our goal is to make this the most pleasant dental experience for you. We strive to provide comprehensive and affordable dental services. To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. The more information that we have, the better we can determine the treatment that is best and most affordable for you!

- What is/was your occupation? _____
- Who may we thank for referring you to Pinebrook Dental? (Name/Address/Phone)

_____

- What is the primary concern/reason for your visit? _____
- Have you had a negative dental experience in the past? If YES, please tell us about it?

_____

- Do you dislike the color of your teeth? **YES** **NO**
- Do you have spaces between your teeth that bother you? **YES** **NO**
- Do you have chips or uneven edges on your teeth? **YES** **NO**
- Do you feel that your teeth are too long or too short? **YES** **NO**
- Do you have dark fillings, existing crowns or dental work you consider "ugly"? **YES** **NO**
- Do your gums show too much when you smile? **YES** **NO**
- Has anyone (family member, friend, etc.) ever suggested that you should have something done with your teeth or smile? **YES** **NO**
- Are you self conscious of your teeth or avoid smiling in photos? **YES** **NO**
- Have you used Smile Direct or any "self service" orthodontic appliance. If YES, which? **YES** **NO**
- Do you use a night guard, snore appliance or sleep appliance? If YES, which? **YES** **NO**
- Do you use a Vape, E-cig or any other smokeless tobacco device? **YES** **NO**
- Would you like to improve your existing smile? If YES, please provide detail **YES** **NO**

_____

Have you been diagnosed with any of the following disorders:

☐ Depression
☐ Anxiety
☐ Sleep Apnea
☐ Food Allergy
☐ Other Allergy

Which of the following are concerns you have regarding dental treatment to improve your smile:

☐ Fear of treatment
☐ Time of treatment concerns
☐ Financial Concerns
☐ Distance to office
☐ Not understanding treatment
☐ Embarrassment
☐ Other: _____

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Financial & Appointment Policy

At **Pinebrook Dental**, we are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy. Payment for services is due at the time services are rendered. We accept cash, checks, debit, Visa, MasterCard, Discover, American Express, Care Credit and Lending Club.

Returned checks are subject to a $30.00 fee. Balances older than 30 days may be subject to additional collection fees and interest charges of 1 1⁄2 percent per month.

If you have dental benefits, we will assist you in obtaining your maximum allowable per year. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range (UCR) by most companies and therefore are covered up to the maximum allowance determined by each carrier. UCR is defined as "usual, customary and reasonable fees for this region." This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area.
3. Some insurance companies arbitrarily select not to cover certain services in their contracts.

I hereby ask and authorize payment from my insurance company directly to **Pinebrook Dental** . It is considered a method of reimbursement for fees paid to the doctor and is not a substitute for full payment. I also understand that I am responsible for all costs of dental treatment, including, but not limited to, any fees my insurance company does not cover. I also authorize the release of any information relating to my claim. In the event of a problem, I hereby ask and authorize **Pinebrook Dental** to speak to the Insurance Commissioner on my behalf.

I also authorize that insurance overpayment will remain in my account as a credit balance toward future services and are not transferable. Reimbursement requests for overpayment may be made in writing. Refunds will be made in the same manner as the initial transaction and may take up to 4 weeks to process.

Should it be necessary to collect my account through an attorney or collection agency, I hereby agree to pay all costs of collection, including attorney's fees, collection costs and court costs.

☐ **I acknowledge that I have read and fully understand the above information and agree to its conditions.**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **Pinebrook Dental** reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

☐ **I acknowledge that I have read and fully understand the Appointment & Cancellation Policy.**

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

Patient Signature: _____ **Date:**_____

Acceptance by Pinebrook Dental: _____ **Date:**_____

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HIPAA Information & Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14th, 2003. Many of the policies have been our practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

Pinebrook Dental has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide service or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You may have the right to request in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to your request.

☐I authorize **Pinebrook Dental** to release any information regarding my dental health to:_____ _____ _(_____)_____

Name Relation Phone #

☐I authorize **Pinebrook Dental** to release any information regarding my dental heatlh to:_____

Name Relation Phone #

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION AND CONSENT FORM and any subsequent changes in **Pinebrook Dental** Associates' policy. I understand that this consent shall remain in force from this me forward.

_____ _____ _____

Print name Signature Date

PINEBROOK
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CONSENT FOR TREATMENT

I hereby authorize **Pinebrook Dental** and whomever they may designate as his/her assistants to perform upon me the following operations and/or procedures for dental treatment. If any unforeseen condition arises in the course of the designated operations and/or procedures calling in their judgment for procedures in addition to or different from those now contemplated, I further request and authorize him/her to do whatever he/she deems advisable.

I consent to the proposed treatment plan after being advised of the alternate plans of treatment available, the known material risks of the treatment to be used, and the consequences if this treatment were withheld. I am informed fully and understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swellings or bruising, discomfort, stiff jaws, and loss or loosening dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissue, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I further consent to the administration of local or general anesthesia, antibiotics, analgesics or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risks include adverse drug response (e.g., allergic reactions), cardiac arrest, aspiration and thrombophlebitis (e.g., irritation and swelling of a vein), discomfort, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

I hereby authorize the **Pinebrook Dental** provider to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

A more complete explanation of all complications of surgery and anesthesia is available to me upon my request from the Doctor.

I realize that in spite of the possible complications, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation/procedure(s). I realize that it is mandatory that I give as accurate and complete medical and personal history as possible, follow any and all instructions as directed, and permit prescribed diagnostic procedures.

PATIENT SIGNATURE: _____. DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

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Treatment for Minor Consent

At **Pinebrook Dental** one of our most important policies is to "inform before we perform." Before we begin treating your child, we ask your permission for periodic dental examinations, x-rays, dental cleanings and fluoride applications. We also need your permission to perform dental treatments, restorations and/or appliances as needed to return all teeth to health and proper function, using local anesthetic and a comfortable mouth prop.

Although our goal is the best oral health for your child, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

A visit to the dental office presents the young child with lots of new and unfamiliar experiences. All efforts will be made to gain the confidence and cooperation of our young patients via warmth, humor, gentle understanding, simple explanations and demonstrations, positive reinforcement and friendly persuasion. High quality and gentle dental care for children is our goal.

Please confirm the name of the minor that you are consenting treatment for:

_____

What is your relationship to the minor? _____

☐ **I have authority and give consent to Pinebrook Dental to perform dental treatment on this minor.**

Signature of Parent or Guardian: _____ **Date:**_____

Acceptance by Pinebrook Dental: _____ **Date:**_____