Barry Family Dental Group

WELCOME TO OUR OFFICE – THE INFORMATION REQUESTED ON THIS GET-AQUAINTED FORM IS IMPORTANT TO OUR RECORDS AND YOUR HEALTH. PLEASE FILL OUT COMPLETELY.

PATIENT INFORMATION

Patient's Name _____ Birth Date _____ Age _____
full name

Address _____ Phone _____ SS# _____
City State Zip

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Full Time College Student? ☐ School Name _____

Email _____ Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Patient _____ Social Security # _____ Date of Birth _____

Home Address _____ Phone _____

Employer _____ Occupation _____

Business Phone _____

Spouse's Name _____ Social Security # _____ Date of Birth _____

Spouse's Employer _____ Phone _____

Name(s) of other family members seen by us previously? _____

Name of nearest relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you? _____

Insurance Information

PRIMARY INSURANCE SUBSCRIBER INFO:

_____ _____
LAST FIRST MI SS#

_____ _____
BIRTHDATE(MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____ _____
EMPLOYER DENTAL INS. CO

_____ _____
ADDRESS PHONE # OF INSURANCE CO GROUP #

SECONDARY INSURANCE SUBSCRIBER INFO:

_____ _____
LAST FIRST MI SS#

_____ _____
BIRTHDATE(MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____ _____
EMPLOYER DENTAL INS. CO

_____ _____
ADDRESS PHONE # OF INSURANCE CO GROUP #

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits be paid directly to the dentist and I am financially responsible for services not paid within 45 days. I further authorize the dentist to release any medical or dental information requested.

SIGNED _____ Date: _____

If patient is under 18

I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

_____
Signature of Parent or Guardian

Patient Name: _____

DENTAL-MEDICAL HISTORY

Please answer each of the following questions for our records and your dental history.

Name of Medical Doctor _____ Phone _____

1. Do you have, or have had, any of the following diseases or problems? Check the box if yes

☐ Taken Phen-Fen	☐ Tuberculosis	☐ Any Blood Disorder
☐ Rheumatic Fever	☐ Abnormal Bleeding	☐ Epilepsy
☐ Abnormal Heart Condition	☐ Diabetes	☐ Anemia
☐ Any Allergies	☐ Hepatitis, Jaundice, Liver Disease	☐ Cancer
☐ Sinus Trouble	☐ Rheumatism or Arthritis	☐ Stroke
☐ Asthma	☐ Stomach Ulcers	☐ Glaucoma
☐ Fainting Spells or Seizures	☐ Kidney Trouble	☐ Pacemaker
☐ AIDS		

	Yes / No
2. Are you in pain?	☐☐
3. Are you now, or have you been under the care of a physician during the past two years?	☐☐
4. Are you presently using any prescription drugs?	☐☐
5. Have you ever experienced any ill effects from Novocain, Penicillin or other drug?	☐☐
6. Have you ever experienced any unfavorable reaction to dental treatment	☐☐
7. Are your teeth sensitive to heat or cold, sweet or sour?	☐☐
8. Do you have a problem with bleeding gums?	☐☐
9. Do you have a problem with food wedging between your teeth?	☐☐
10. Do you have frequent bad breath or an unpleasant taste in your mouth?	☐☐
11. Have you ever had a problem with thumbsucking, nailbiting, or tongue chewing?	☐☐
12. Do you clench or grind your teeth or get headaches often?	☐☐
13. Do you wake up with sore muscles in your face or neck?	☐☐
14. Do you have any allergies?	☐☐
15. Have you received any type of artificial joint replacement (hip, knee etc.)?	☐☐
16. Are you currently taking, or have you in the past, any medications for osteoporosis? (Fosomax, Actonel, Boniva, etc.)	☐☐

If any of the above answers are yes, please explain.

Women: Are you pregnant? _____

When did you visit a dentist last? _____ Last Cleaning? _____

How often do you brush your teeth? _____ How often do you floss? _____

Are you happy with the appearance of your teeth? _____

Color? _____ Shape? _____ Position? _____

If you could change anything about your teeth what would it be?

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-in-Lending Act which requires all doctors to give their patients information in connection with extension of credit please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time of treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 90 days from the date of first billing to pay 1.75% per month on the unpaid balance (annual rate of 21%)
3. Allow our office to obtain your credit rating.

I/we agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Barry Family Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:

SECTION B: TO THE PATIENT-PLEAE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information and or other important matters about your protected health information. A copy of our notices is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting:

Contact Person: Office Manager/Financial manager
Telephone: (801) 226-0441/226-0442 Fax: (801)226-4754
E-mail: info@barryfamilydental.com
Address: 1943 North State Street Orem, UT 84057

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I give my permission for Barry Family Dental Group to disclose my dental health information to a family member, friend or other person to the extent necessary to help with my healthcare of with payment for my health care. Yes ☑ **No** ☐

I Patient Name: _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representative's Name _____

Relationship to Patient _____

Financial Policy:

Payment is due at the time of service. If you are unable to pay your portion in full at the time of service you must apply for Care Credit, an outside financing company, to help assist you with your financial needs. Or, you may find your own outside financing that best fits your financial needs. If you apply for Care Credit but do not qualify with them for assistance you must establish a payment history with our office before we are able to make any financial arrangements. Unfortunately, we are unable to carry account balances longer than 60 days within our office

Your payment options are as follows:

- Cash or Check
- Credit Card (Visa, Mastercard, Discover, American Express)
- Apply for Care Credit (outside financing)
- If you use Care Credit there may be processing fees.

Billing:

Our office sends billing statements. Payments are due upon receipt of your billing statement. Our billing statement lists a balance, an estimated insurance portion and an estimated patient portion. The patient portion is expected to be paid in full unless prior arrangements have been made with the Office Manager. Balances older than 90 days will be subject to finance charges at 21% APR.

Insurance:

Dental insurance helps assist the patient with their dental health needs. Our office files insurance claims and accepts insurance checks as a service to our patients. We do expect a patient's estimated portion to be paid at the time of service even when the patient has dental insurance coverage. We cannot provide the exact amount your insurance will assist you with for your dental needs. Your dental insurance coverage is strictly a function of the policy selected by your employer. We cannot guarantee that your dental insurance will assist you with your services that will be provided even if we pre-authorize. Please stay in contact with your dental insurance company regarding your benefits, coverage and procedures provided to help ensure payment. Any balance remaining after your dental insurance pays is due by the 20th of the next billing cycle. You accept full responsibility to pay in full immediately if your dental insurance company has not paid within 60 days of service. If you overpay due to an estimated patient portion, we would be happy to hold the credit on your account for future services provided or reimburse you.

Other Information:

- Barry Family Dental Group offers a 15% discount to any patient that does not have dental insurance and pays at the time of service. This discount does not apply unless balance owing is paid in full at the time of service.
- We do charge a returned check fee ranging from $5.00-$20.00 depending on the amount of the check.
- Broken or missed appointments with less than 2 business days notice may be subject to a fee up to $50.
- If it becomes necessary to refer an account to our collection agency, we will charge a collection fee up to 40% of the balance owing.
- I grant permission to BFDG to telephone me at home or work to discuss matters related to this form.
- This agreement supersedes any other agreement and by signing this agreement any arbitration/mediation agreements previously signed are null and void.
- I/we agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Courtesy discounts are not applied to any dental services that are eligible for a contracted insurance write-off

Discounts cannot be combined.

Thank you for reviewing our policies. We make every effort to explain your costs and avoid misunderstandings so that we can focus on your dental health. If you have questions, please ask. We are here to serve you. At any time, please feel free to request a copy of this document. I have read, understand, accept and agree to abide by the terms stated above.

Responsible Party _____ Date _____