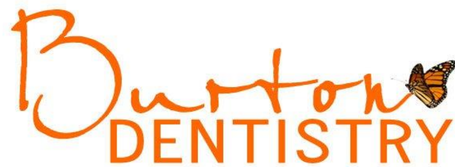

Burton Dentistry No Show/Cancellation Policy

EFFECTIVE 05/01/2014

Dear Patient,

Thank you for entrusting your dental care to Burton Dentistry! We are dedicated to providing you with the best possible care in a friendly and efficient environment. To achieve these objectives, we must develop a cooperative and symbiotic relationship with our patients. In fostering this relationship, we have streamlined the appointment process to provide greater coordination of patient flow within our office. One of the foundations of the policy is an appointment reminder system. This system sends reminders at strategic time intervals before each appointment; therefore, we require patients to provide us with an E-mail address and a cell phone number to facilitate the reminders. Patients are also required to respond to the reminders, either by confirming or canceling their appointments as instructed, as we will no longer place courtesy reminder calls.

If you do not respond to the reminders, your appointment may be assigned to a patient on our waiting list. If you need to cancel your appointment, please provide a minimum of 48 hours. Our no show/cancellation fee is $50.00.

PATIENT PRIVACY & PRACTICE POLICIES (PLEASE INITIAL ALL ITEMS BELOW)

DENTAL RECORDS RELEASE: The practice requires a $10.00 fee for researching, copying and mailing (if applicable), each dental record. The fee is due in full prior to their release. _______Initials

FINANCIAL: Your understanding of our financial policies is an essential element of your care and treatment. For your convenience we accept cash, checks (minimum $20.00), Visa and MasterCard. Full payment is due at time of service. There is a $50.00 returned check fee.

_________Initials

INSURANCE: We have made prior arrangements with many insurance plans. We will bill those plans with which we have an arrangement and will collect co-pays and/or deductibles at the time of service when you arrive for your appointment. In the event your dental plan determines a service to be non-covered, you will be responsible for the complete charge. Subsequently, we will bill you directly and payment is due upon receipt of the statement. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. ______Initials

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay for the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. ________Initials

CANCELLATION: To avoid a fee of $50.00, please do the following:

*Allow 48 hours advance notice when cancelling your appointment. _______Initials

I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.

____

SIGNATURE OF PATIENT (PARENT OR GUARDIAN)

_________________________________ _____________________________

PRINT NAME OF PATIENT (MINOR) DATE

Health History Form

Dr. Francesca M. Burton, D.D.S., P.C

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: Mailing address
City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ____________ If yes, have you had any complications? ____________			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ____________			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ____________			
If yes, how much do you typically drink In a week? ____________			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: ____________			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____________	☐	☐	☐
Aspirin ____________	☐	☐	☐
Penicillin or other antibiotics ____________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐	☐
Sulfa drugs ____________	☐	☐	☐
Codeine or other narcotics ____________	☐	☐	☐
Metals ____________	☐	☐	☐
Latex (rubber) ____________	☐	☐	☐
Iodine ____________	☐	☐	☐
Hay fever/seasonal ____________	☐	☐	☐
Animals ____________	☐	☐	☐
Food ____________	☐	☐	☐
Other ____________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ____________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ____________			
Recurrent Infections	☐	☐	☐
Type of infection: ____________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: ____________ Phone: ____________

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: ____________ Date: ____________

FOR COMPLETION BY DENTIST

Comments: ____________

Insurance Verification Form

Dear New Patient,

The Information you will provide will be kept confidential as per HIPPA regulations. As a service to our patients, we accept and file dental insurance. However, **YOU** are responsible for **ALL** communication with your insurance company except for additional information required of this office pertaining to specific procedures. Please understand that dent insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible which must be paid by the patient at the time of service. **We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.**
Thank you for your cooperation!

Please provide the following information from your dental insurance card:

Patient's Name: ______________________________ D.O.B:_____/______/__________

Name of Policy Holder: ______________________________

Relationship to Policy Holder: ______________________________

Policy Holder's Social Security Number: ________-_________-_________ Policy's Holder D.O.B:____/____/____

Policy's Holder Employer Name: ______________________________

Dental Insurance Company Name: ______________________________

Group Number: ______________________________

Insurance Company Phone Number: ______________________________

Insurance Company Claims Address: ______________________________

Authorization

I certify that I am covered by__________________ insurance company and I assign directly to Dr.__________ all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________ Signature

_____/_____/__________ Date

Burton Dentistry, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ____________________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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