ACQUAINTANCE FORM

The information you give us is strictly confidential and will not be released to anyone without your permission.

PATIENT INFORMATION

Patient's Name_____ Email address_____

Address_____

Home #_____ Cell# _____ Social Security #_____ Date of Birth_____

Employer Name_____ Work Telephone_____

Marital Status_____ If Married, Spouse's Name_____

How Did you Happen To Chose Our Office? (Please circle) Magazine Google Location Personal Referral:_____

EMERGENCY INFORMATION

In Case of Emergency Contact_____ Relationship _____

Address_____ Telephone_____

RESPONSIBLE PARTY INFORMATION

Person Responsible For Payment_____ Relationshp_____

Address_____

Telephone_____ Social Security #_____ Date of Birth_____

INSURANCE INFORMATION

Dental Insurance Company Name_____

Address_____

Group #_____ Subscriber Name_____ Social Security #_____

IF DUAL COVERAGE--THE SECONDARY INSURANCE COMPANY:

Insurance Company Name_____ Employer_____

Address_____ Group #/Policy #_____

Relationship_____ Subscriber Name_____ Social Security #_____

MEDICAL HISTORY *Please check or circle any of the following which you **have** or **have had** and explain where necessary. List prescribed medications you are taking now for each.*

1. AIDs_____
2. Anemias or Blood Discrasias_____
3. Arthritis, Rheumatoid or Osteo_____
4. Asthma_____
5. Autoimmune Conditions_____
6. Birth Control Pills, Hormone Replacement Therapy or Fertility Problems_____
7. Blood Clots or Stroke: Y/N Treatment: _____
8. Bone Problems, Osteoporosis_____Treatment w/Bisphosphonates(Please circle or write): Fosamax Actonel Boniva Zometa oral or injection Other:_____
9. Cancer or Tumors: Y/N Current Treatment:_____ Previous Treatment:_____
10. Depression or Nervous Disorders_____
11. Diabetes: Type I or Type II A. Oral Medication_____ B. Insulin Injections_____
12. Digestive Conditions, Acid Reflux, GERD_____

13. Epilepsy or Seizures: Y/N Last episode:_____

14.Hayfever or Allergies other than medications_____

15.Heart Problems_____

A. Cardiac Bypass Surgery_____ B. Cardiac Pacemaker_____

C. Congenital Heart Defect_____ D. Prosthetic Heart Valve_____

E. Heart Attack_____ F. Heart Murmur, Mitral Valve Prolapsed_____

16. Hepatitis A,B, C or Liver Disease_____

17.High Blood Pressure_____ 18. Low Blood Pressure_____

19. Joint Replacement_____ Premedication: Y/N Antibiotic:_____

20. Kidney Disease _____

21. Lung Disease, COPD_____

22. Muscle Diseases_____

23. Social Diseases_____

24. Thyroid Diseases_____

25. Tuberculosis or Symptoms of Tuberculosis_____

26. Other diseases or conditions not listed_____

Please list any vitamins, supplements or herbal/homeopathic remedies that you are currently taking:

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following:

Antibiotics 1.Penicillin 2.Erythromycin 3.Tetracycline 4.Sulfa 5.Keflex 6.Clindamycin 7.Other_____

Local Anesthetics like Lidocaine or Septocaine or Carbocaine_____ Epinephrine sensitivity_____

Aspirin Codeine Ibuprofen, Motrin, Advil Aleve Narcotics_____

Latex Metals of any kind_____

Other allergies to materials or medications_____

Have you ever been advised to take medication (antibiotics or other medications) before a dental appointment? Y/N (circle) **If so, please explain**_____

Have you ever had a skin rash or a reaction to metal jewelry? Y/N (circle) To What?_____

Do you wear contact lens? Y/N (circle) Do you bleed excessively upon injury? Y/N (circle)

Do you drink alcohol? Y/N (circle) _____daily _____weekly _____monthly _____ socially_____

Do you smoke now or **have you ever** smoked? Y/N (if yes number of years) cigarettes/day_____

cigars_____ pipes_____ chewing tobacco or snuff_____

Women: Is there a possibility that you may be pregnant or trying to get pregnant? Y/N (circle)

If yes, how many months pregnant? _____

Are you in a job that regularly exposes you to radiation or chemicals? Y/N (circle) _____

Have you ever had counseling for addictions to alcohol and/or prescription medications? Y/N (circle)

Do you have reason to believe you are at risk for contacting infectious or sexually transmitted diseases?

Y/N (circle) If yes, please explain_____

Have you been hospitalized in the past two years Y/N (circle) If yes, please explain_____

_____

Physicians name and phone #:_____Date of last physical_____

Are you experiencing emotional or physical stress or pressure in your work or at home? Y/N (circle)

Please explain_____

Is there anything other in your medical history that we have missed? _____

DENTAL HISTORY

Name and contact # of previous Dentist_____

Date of last visit_____ Were x-rays taken? Y/N (circle)_____

Have you had regular cleanings and exams? Y/N (circle)

Do you have a fear or phobia or the dentist that prevents you from visiting the dentist on a regular basis? Y/N (circle)

Would you be interested in help to deal with this fear, such as the use of Nitrous Oxide? Y/N (circle)

Have you lost teeth? Y/N (circle) Why?_____

Have you had complications with extractions?_____

Have you worn braces?_____ When?_____ How Long?_____ Do you still wear retainers?_____

Have you had treatment for periodontal disease (gum disease) or where you told you had periodontal disease?_____ Please explain and give dates_____

How often do you brush your teeth? ____x/day AM___PM___ Do you floss?_____x/day

Do you use other hygiene aids?_____

Do your gums bleed when you brush?____ or floss?_____

Do you have an unpleasant taste in your mouth?_____

Are there any areas of your mouth where foods collects or wedges between your teeth?_____

Have you noticed a dry mouth? Y/N Excessive water drinking/sipping? Y/N Frequent Use of Lozenges? Y/N

Do you have clicking or popping sounds when you open or close your mouth?_____ Pain?_____

Do you clench or grind your teeth either during the day or at night?_____

Do you experience headaches?_____ Frequency? _____When do they come?_____

Are any of your teeth sensitive?_____ Sweets? _____Cold?_____ Hot?_____ Pressure?_____

Are you interested in mercury safe removal of amalgam (mercury) fillings?_____

TREATMENT AUTHORIZATION

I consent to whatever dental procedures and anesthetics are necessary for treatment. I also understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature of Patient or Guardian_____Date_____

Signature of Dentist_____Date_____

BUEHNER FAMILY DENTAL CARE

Acknowledgement of Receipt of Notice of Privacy Practices

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practice.

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)_____

_____

BUEHNER FAMILY DENTAL CARE

Co-Insurance and Deductible Policy

We would like to thank you for choosing us as your dental provider. We are committed to providing you with quality dental care. Buehner Family Dental Care has begun to participate with many more insurance companies which has allowed our office to provide an even wider range of services for many in the community. As part of a contract that the dental office signs with an insurance company we must collect co-insurance and deductibles at the time of service.

If there is concern as to if one will be able to pay the deductible or co-insurance please speak to the front desk prior to being taken back for treatment. Payment arrangements will be discussed and can be agreed upon if at least a portion of the visit's co-payment or deductible is paid on the date of service.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid by you or your employer. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

However, it should be understood, that the dental insurance contract is between the insurance co. and the patient. **Ultimately, financial responsibility falls on the patient**.

I have read and understand this document as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date

BUEHNER FAMILY DENTAL CARE

Financial Policy

We would like to thank you for choosing us as your dental provider. We are committed to providing you with quality dental care and a clear understanding of our financial policy. Please understand that the payment of your bill is considered a part of your treatment. This is a breakdown of our policy which we require you read and sign prior to treatment. All patients must also complete a Patient Information/Health History and an Acknowledgement of Receipt of Notice of Privacy Practices before being seen by the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS COVERED BY PARTICIPATING INSURANCE CARRIER. WE WILL GLADLY ACCEPT MASTERCARD, VISA, DISCOVER, DEBIT CARDS, CASH OR PERSONAL CHECK. WE ALSO OFFER PAYMENT PLANS FOR TREATMENT AT OUR DISCRESSION.

Regarding Insurance: **All charges you incur at each dental visit are your responsibility regardless of your insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. It is ultimately the patient's responsibility to know details of your dental benefits. It is also the patient's responsibility to verify if the practice is in or out of network with his or her insurance policy and to be aware of your maximum allowance. As a courtesy, it is our staff's only responsibility to assist patients in filing out and submitting the insurance claim. Patients with dental insurance will be responsible to pay the estimated insurance copayment of a procedural allowance and deductible at the beginning of treatment. As well as, authorize the assignment of the insurance benefits to us. After insurance benefits are received, if there is an overpayment, a refund will be sent to you. **If there is an additional amount due, we will send a statement balance. If it is a non participating insurance, any charges incurred in our office are your responsibility at time of service**; we will still file your insurance claim, and will mark the payment as payable to you directly. Your insurance claim can **ONLY** be submitted if we are supplied with the proper insurance information from you (i.e.: **insurance company address and phone number, subscriber's identification number and group number**). It is your responsibility to make sure your policy is active on your date of service. If your insurance company has not paid your claim within 45 days please contact your insurance company. Your dental plan may not cover certain procedures; however this does not mean these treatments are unnecessary. If you have questions regarding your dental plan, or a problem with a reimbursement level, contact your employer or insurance company. Our staff may be able to explain dental plan issues to you. But, it is your responsibility to be educated on the levels of coverage provided by your plan. **Patient's Initials: _____**

Usual and Customary Rates: Our practice is committed to providing good treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what is an appropriate charge.

Missed appointments: The first missed appointment will generate a letter outlining our policy.
The second missed appointment (within a 12 month period) will generate a charge of $35, plus a warning letter.
The third missed appointment (within a 12 month period) will generate a second charge of $50 and may cause dismissal from our practice.

Returned Checks: Patients will be charged $50 for each returned check, and are responsible for the amount owed.

Accounts: After 60 days from the date of service a 35% collection fee will be added to your account if there has been no attempt to make payment or set up a payment schedule. All accounts delinquent over 90 days and without a payment schedule will be turned over to a collection agency for further collection procedures. All past due accounts must be paid in full before you can schedule another appointment.

I have read and understand the financial policy as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date