Welcome

Thank you for choosing to visit our dental office. It is a pleasure to meet you! To serve you best, please take a moment to provide us with some important information. Your responses are greatly appreciated.

STALEY SMILES
DENTAL CARE

Today's Date _____

Name _____
First Middle Init Last

Preferred Name _____ Single Married Divorced Widowed

Birthdate _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Home Phone _____

E-Mail Address _____

How Did You Hear About Us _____

Emergency Contact: _____

Relation _____ Phone _____

Primary Dental Insurance Information

Insurance Company _____ Phone _____

Employer _____ Group Number _____

Insured's Name _____ Date of Birth _____

Insured's SSN _____ Member ID _____

Secondary Dental Insurance Information

Insurance Company _____ Phone _____

Employer _____ Group Number _____

Insured's Name _____ Date of Birth _____

Insured's SSN _____ Member ID _____

Medical History

Patient's Name_____ Physician's Name _____

Please list **ALL** prescription medications, over-the-counter medications, and supplements you are currently taking.
This is **extremely** important! We must know all current meds because they can affect your oral health.

_____

_____

Have you ever taken Actonel, Boniva, Fosamax, Reclast or any other bisphosphonate for osteoporosis _____

Have you ever been prescribed an antibiotic to take before your dental visits _____

List any surgeries, serious illnesses, conditions, or hospitalizations you have had recently:

_____

Are you allergic to any of the following:

____ Acetaminophen	____ Iodine	____ Penicillin
____ Codeine	____ Latex	____ Sedatives
____ Ibuprofen	____ Local Anesthetic	____ Sulfa
____ Erythromycin	____ Metal	____ Tetracycline
		____ Other _____

Please check if you have or have had any of the following:

____ AIDS / HIV	____ Currently Nursing	____ Low Blood Pressure
____ Acid Reflux	____ Diabetes	____ Lung Disease
____ Allergies	____ Emphysema	____ Mitral Valve Prolapse
____ Anaphylaxis	____ Epilepsy / Seizures	____ Organ Transplant
____ Anemia	____ Excessive Bleeding	____ Osteoporosis
____ Angina	____ Fainting / Dizzy Spell	____ Pacemaker
____ Anxiety / Depression	____ Frequent Headaches	____ Renal Dialysis
____ Arthritis	____ Glaucoma	____ Rheumatic Fever
____ Artificial Heart Valve	____ Heart Attack/Failure	____ Rheumatoid Arthritis
____ Artificial Joint	____ Heart Murmur	____ Shingles
____ Asthma	____ Hepatitis	____ Sinus Problems
____ Back Problems	____ High Blood Pressure	____ Sleep Apnea
____ Cancer	____ High Cholesterol	____ Stomach Problems
____ Cardiovascular Disease	____ Hives / Rash	____ Stroke
____ Chemotherapy / Radiation	____ Immune Deficiency	____ Thyroid Disease
____ Cold Sores	____ Irregular Heartbeat	____ Tobacco Use
____ Congenital Heart Disorders	____ Jaundice	____ Tuberculosis
____ COPD	____ Kidney Problems	____ Tumors / Growths
____ Currently Pregnant	____ Liver Disease	____ Ulcers

Any Illness **NOT** Listed Above_____

I affirm that the medical information provided here is correct to the best of my knowledge:

_____ _____

Signature Date

TREATMENT CONSENT

Please read this form carefully and ask about anything you do not understand

State law requires us to obtain consent for dental treatment. That may include but is not limited to:

- Radiographs
- Cleaning and Fluoride
- Sealants
- Fillings
- Root Canals
- Crowns and Bridges
- Implants
- Extractions
- Partials and Dentures

Possible complications of dental treatment, although not frequent, may include but is not limited to:

- Injury or numbness of lips, chin, cheeks, tongue, gums, and/or nerves from procedures and/or administration of local anesthetic, which is usually temporary but may be permanent
- Damage and/or fracture to teeth, jaw, and/or existing restorations
- Pain, swelling, bruising, and/or bleeding
- Nausea, vomiting, and/or allergic reaction to fluoride and/or local anesthetic
- Infection. Some medical conditions may require an antibiotic prior to dental appointment. Discuss **ALL** medical conditions, prior procedures, and surgeries with Dr. Barton prior to any treatment

I have read and understand this consent form and have no further questions. I authorize Dr. Thomas F. Barton DDS, who may be assisted by other dental professionals, to perform dental treatment on myself and/or my child.
All minors MUST be accompanied by a parent or guardian.

Patient Name _____

Signature _____ Date_____

Relation to Patient_____

Financial Policy

- Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. An additional fee of $35 will be applied for returned checks. We will be happy to help you apply for CareCredit, a 0% credit card used for healthcare services, which allows you to make affordable monthly payments. You may qualify for interest free financing for up to 24 months. Ask for an application or go to www.carecredit.com to start the pre-approval process.
- As a courtesy to you, we will be happy to file your claims. We will provide you with an estimate; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency and age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for details of your benefits.
- All charges you incur are your responsibility, regardless of your insurance coverage. Dr Barton will recommend treatment based on what is best for your dental health, NOT your insurance coverage. As your dental provider, our relationship is with you, not with your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
- Insurance payments are ordinarily received within 20-60 days from the time of filing. If your insurance company has not made payment within **45 days**, we may ask that you contact your insurance company to make sure payment is expected. If payment is not received within **90 days** from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payments from your insurance company after you have paid your bill in full, we will remit the payments directly to you.
- When we schedule your appointment, the time is reserved exclusively for you. When you fail to notify us of your inability to keep an appointment, another patient in need of dentistry is unable to receive treatment. We request that you give us at least 24 hours' notice when you realize that you cannot keep an appointment. When the requested notice is not given or you do not show, a fee of **$50** will be charged. Multiple missed appointments without adequate notice will result in dismissal from our practice

I have read the above information and have no further questions and accept these terms.

_____ _____

Signature Date

Notice of Privacy Practices

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will 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 Practice 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 of other important matters about your protected health information. A copy of our notice accompanies this consent. 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 health information that we maintain.

RIGHT TO REVOKE

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any actions 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 your revoke this consent.

I have had full opportunity to read and consider the contents of this consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: _____Date: _____

Print Name: _____

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

Personal Representative's Name:_____

Relationship to patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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

Staley Smiles Dental Care
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816-453-0195