dickinson&branon
dental care

12 Mapleville Depot Road
802-527-1227
info@dbdentalcarevt.com
www.Smile-Vt.com

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Emergency Contact: _____ Relatioship: _____ Phone: _____

How did you hear about our office?

_____

2. Reason for today's visit (your primary concern):

_____
_____
_____
_____

3. Your secondary concerns:

_____
_____
_____
_____

4. Level of anxiousness about visiting the dentist:

1 = None / 5 = Uncomfortable / 10 = Hiding under the bed

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If greater than 3, please share your feelings:

_____

5. On a scale of 1 to 10, with 10 being the highest, how important is your dental health to you?

_____

6. If you could change something about your smile what would it be?

- ☐ Whiter
- ☐ Straighter
- ☐ Close Space
- ☐ Replace black mercury filling with tooth colored restorations
- ☐ repair chipped teeth
- ☐ replace missing teeth
- ☐ less gums showing
- ☐ replace old crowns or caps that don't match

7. What questions would you like to have answered at your appointment?

_____

_____

_____

_____

8. What would you like to see happen with treatment?

_____

_____

_____

_____

9. Is there anything else you would like us to know before your visit?:

_____

_____

_____

_____

INSURANCE INFORMATION

10. Who is responsible for your account and payment? (if different from previous listing)

Address: _____ Apt. / Unit #: _____ Birthdate: _____

Phone: _____ Email: _____

11. Primary Dental Insurance

Insurance company: _____ Phone # _____ Subscriber's Social Security # _____

Address: _____ Group #: _____ ID#: _____

How much is your deductible? _____ How much have you used? _____

What is your annual maximum benefit? _____ Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____ Address: _____

12. Secondary Dental Insurance

Insurance company: _____ Phone # _____ Subscriber's Social Security # _____

Address: _____ Group #: _____ ID#: _____

How much is your deductible? _____ How much have you used? _____

What is your annual maximum benefit? _____ Whose name is this insurance under? _____

Employer offering this insurance? _____ Phone: _____ Address: _____

DENTAL HISTORY

13. Dental History

Date of last dental care visit: _____ Date of last dental x-rays: _____ Former dentist's name: _____ Phone #: _____

14. Check if you have any problem with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Sensitivity to any of the following: cold, hot, sweets
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Food collection between certain teeth
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth
- ☐ Grinding teeth

15. Daily Dental Care

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

MEDICAL HISTORY

16. Physician Information

Your physician: _____ Date of last visit: _____

17. Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"?

○ Yes ○ No

18. Have you had any serious illnesses or operations? If yes, please describe.

_____

_____

_____

_____

19. Women

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Are you taking birth control? ○ Yes ○ No

20. Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV AIDS
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Sexually transmitted disease
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer

21. List medications you are currently taking and the correlating diagnosis:

	Medication	Diagnosis
1		
2		
3		
4		

22. Please list any allergies you may have:

	Allergy
1	
2	
3	
4	

23. Indicate any history of (check all that apply); If checked "Yes", please explain.

	Yes	No	Explain
Thumb/finger sucking			
Injury to face or teeth			
Tongue and/or swallowing problems			
Speech problems			
Tonsils removed			
Crowns/Bridges			
Fillings			
Root canals			
Grinding and/or clenching of teeth			
History of wearing a mouthguard at night			
History of Periodontal disease			
Snoring			
Orthodontic Treatment			
Headaches			

24. Airway

	Yes	No	Explain
While Awake: Mouth breathing preferred to nose breathing			
While Asleep: Mouth breathing preferred to nose breathing			

25. Sleeping pattern

	Yes	No	Explain
Move around a lot			
Usually takes less than 10 minutes to fall asleep			
Snoring			
Obstructive Sleep Apnea			

26. Pain / Symptoms

	Yes	No	Explain
Tooth pain/sensitivity			
Jaw joint pain			
Popping/clicking in jaw joint(s)			
Jaw muscle stiffness			
Head/Neck muscles stiffness			
Neck pain			
Headaches			

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I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays as may be deemed necessary for the doctor.

If patients is a minor please sign

Parent Full Name	Parent Signature	Date

Patient Signature	Date

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Billing Procedure

Dental Insurance is a benefit from your employer that helps you pay for your dental treatment. It generally does not pay for all of your treatment. Ultimately, you are responsible for paying the cost of your dental treatment.

We will try our best to make the benefit you receive go as smoothly as possible; however, we need your help. As a courtesy, we will file insurance claims on your behalf. To do this we need a copy of your dental insurance card and some additional information.

Generally, dental benefits are reimbursed at different rates, depending on the policy that your employer has purchased. The categories are preventative, basic and major and the reimbursement varies for each employers' individual policy. The insurance companies have a yearly maximum for the dental benefits and this also varies for each employer's individual policy.

Dickinson & Branon Dental Care is NOT a provider for Blue Cross Blue Shield. Payments are due on the day for service for patients with Blue Cross dental benefits. As a courtesy, we file your insurance for you, but the Explanation of Benefits (EOB) and payment will go directly to the employee (you). If you have a secondary insurance policy, we will also file that claim for you, however, some secondary insurance companies will require a copy of the Blue Cross Explanation of Benefits, so please forward this copy from Blue Cross Blue Shield promptly to our office. We can then submit the EOB from Blue Cross and the insurance claim to the second company for additional payment. Failure to submit the Blue Cross Blue Shield Explanation of Benefit (EOB) copy to us in a timely manner may result in finance charges.

All other insurance companies send the Explanation of Benefits (EOB) to our office and to the patients. Co-pays from the patient will be billed to the patient with our bi-monthly billing statements. Statements will continue to be sent on a bi-monthly basis until the account is paid in full. Ultimately, you are responsible for the payment of dental services from our office.

PLEASE CONTACT US IF YOU HAVE ANY QUESTIONS ON PATIENT CO-PAYS OR OTHER QUESTIONS ON YOUR DENTAL BENEFIT. WE ARE HERE TO HELP YOU.

PAYMENT ARRANGEMENT FORM

NAME OF PATIENT:

_____

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on my primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I

will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a finance charge equal to 12% APR if my balance goes beyond 90 days past due; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee of $100.00 for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to a collection agency that a fee of 30% of my current balance will be applied to my balance. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payments directly to the Practice.

_____

Full Name

_____

Date of Birth

_____ _____

RESPONSIBLE PARTY Signature Date

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PRIVACY PRACTICES

Dickinson & Branon Dental Care

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 2, 2021, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare; but only if

you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain

circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Meredith Neary Telephone: 802-527-1227 Fax: 802-527-3767 E-mail: service@dbdentalcarevt.com Address: 12 Mapleville Depot Road, St. Albans, VT 05478

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law. (August 14, 2002; April 30, 2009).

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

• • You May Refuse to Sign This Acknowledgement • •

I have received a copy of Dickinson & Branon Dental Care's Notice of Privacy Practices

_____

_____

UNLESS YOU REQUEST OTHERWISE, we may use or disclose health information to an immediate family member or legal guardian to the extent necessary to help with your healthy care or with payment of your healthy care.

I request the following to NOT have access to my dental/financial records:

_____

_____ _____

Patient Signature Date

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1. Please enter your information.

First Name: _____ Last Name: _____ Date _____ Age: _____

2. Select the column that best describes each symptom that your are experiencing.

	No Occurence	Very Rarely	Occurs 2 -4 Times a week	Occurs 5 - 7 Times a week	Occurs Daily
Snore at all					
Have labored, difficult, loud breathing at night					
Frequent headaches in the morning					
Wake up to go to the bathroom at night					
Mouth breathes during day					
Mouth breathes while sleeping					
Grinds teeth					
Suffer from allergies					
Excessive sweating while asleep, night sweats					
Wakes up at night					
Restless sleep - arm, leg movement					
Have interrupted snoring where breathing stops for 4 seconds					
Frequent throat infections					
Feels sleepy and/or irritable during the day					
Frequent ear infections, ear tubes					
Digestive troubles - reflux					
Scalloped tongue					
Tongue tie					