PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Please Circle whether you are: Married / Single AND Male / Female
Patients Social Security Number: _____ Date of Birth: _____
Street Address: _____
City: _____ State: _____
Zip Code: _____
Employer: _____
Phone Numbers to reach you at: Home _____ Work _____ Cell _____
E-mail Address: _____
Whom may we thank for referring you to our practice?: _____

INSURANCE POLICYHOLDER INFORMATION

Name of Policyholder: _____ Date of Birth: _____
Phone Number of Policyholder: _____
Employer of Policyholder: _____
Social Security Number of Policyholder: _____
Dental Insurance: _____
Group Number: _____ ID Number : _____

ALTERNATE CONTACT INFORMATION

Last Name: _____ First Name: _____
Phone Number: _____ Relationship to Patient: _____

Last Name: _____ First Name: _____
Phone Number: _____ Relationship to Patient: _____
(Not in Household)

Authorization
I understand that I am responsible for all costs of dental treatment. I hereby authorize payment to the Dental Office of the group insurance benefits, otherwise payable to me. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys fees we incur in such collection efforts. Interest shall be collectable at the legally accessible rate on all bills overdue thirty days after service has been rendered. To the extent permitted under applicable law, I authorize release of any information regarding dental treatment to appropriate insurance companies or other health care providers.
Signature of Responsible Party

12 Mapleville Depot, Saint Albans, Vt 05478
802.527.1227 802.527.3767 fax
www.dlbdentalcarevt.com

PATIENT DENTAL HISTORY

Today's Date: _____
Last Name _____ First Name _____ DOB: _____

Do you like your smile? Rate it 1-5 _____ (5 being you are completely happy with it)

Do your gums bleed while brushing or flossing? Yes or No
Do you have any sores/lumps in or near your mouth? Yes or No
Are your teeth sensitive? To What? _____
Have you had prolonged bleeding or pain after extractions? Yes or No

Please circle if you have any of the following jaw symptoms:
popping / clicking / locking / pain / difficulty swallowing

Do you clench and grind your teeth? Yes or No
Do you feel nervous about dental treatment? Yes or No
If yes please explain: _____

MEDICAL HISTORY

Primary Care Physician's Name_____ (If none, please state none)
Are you under medical treatment? If yes explain: _____
Have you ever been hospitalized for any surgical operation or illness? Yes or No Please explain:
_____

Are you currently taking ANY prescriptions, vitamins or over the counter medications? If so please list below:

_____
_____
_____

Do you smoke or use smokeless tobacco? Yes or No If yes how frequently? _____
Do you use alcohol? Yes or No How frequently? _____
Do you use Drugs? Yes or No If so what type? _____
If you are a woman: Are you pregnant? Yes or No Are you nursing? Yes or No

Are you allergic to or have reactions to anything, such as local anesthetics, penicillin, sulfa drugs, barbiturates, sedatives, iodine, aspirin or others? Yes or No Please specify which:

_____

Please Circle if you have or have had any of following:

Angina /Chest Pain	Stroke	Osteoporosis	Respiratory Problem	STD's
Heart Murmur	Joint Replacement	Kidney Disease	Allergies/Hay Fever	AIDS/HIV
Heart Attack	Diabetes	Bipolar	Emphysema	Cold Sores
Rheumatic Fever	Depression/Anxiety	Liver Disease	Tuberculosis	Glaucoma
High Blood Pressure	Acid Reflux	Hepatitis	Asthma	Alzheimer's
Cardiac Pacemaker	Cancer	Thyroid Disease	Epilepsy/Convulsion	
Swollen Ankles	Chemotherapy	Methodone/Suboxone	Fainting History	

Please explain circled conditions:
_____
_____

Please rate these below with how they pertain to you 1-3. (1 being of no concern to you and 3 being a major concern)
Many of our patients have three questions they are hesitant to voice aloud. They are wondering whether they can:

____ Afford dental treatment
____ Have enough time to come in for visits
____ If the treatment will hurt

FINANCIAL OPTIONS

1. For those patients who carry dental insurance, all co-payments are due on date of service. We will file your claim as a service to you, and will do our very best to maximize your benefits. We accept assignment to lower your immediate “out-of- pocket” expenditures.

2. For non-insured patients, payment is due on the day of service.

3. MasterCard, Visa, Discover Card and American Express cards are accepted.

4. For long term payment plans, we offer Care Credit® . Care Credit® is a financing program for dentistry that allows you to make monthly payments, spreading those payments our over a desired time period. (Based on Care Credit® approval)

5. A $35.00 fee will be charged due to insufficient funds on all returned checks.

These financial options will meet the needs of most families in our practice. We want to be flexible in changing times. We will do our very best to work out a financial solution to your particular situation. We are here to help you.

There will be a $50.00 fee for appointments broken with less than 48 hours notice. Fees may be applied if your account is sent to collections.

Yours for Better Dental Health,
Dickinson & Branon Dental Care

Patient’s Signature:_____
Date:_____

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 for the cost of your dental treatment.

We will try our best to make the benefit you receive go as smoothly as possible, but we need your help. As a courtesy, we will file insurance claims on your behalf. To do this we will 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 covered are preventive, basic and major and the reimbursement varies for each employer's 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. As a courtesy, we file your insurance for you but the Explanation of Benefits (EOB) and payment go directly to the employee (you). Payments are due on the day of service for patients with Blue Cross dental benefits. In order for us to bill secondary insurance, we need your help. Some secondary insurance companies will require a copy of the Blue Cross Explanation of Benefits so we need you to forward this copy from Blue Cross Blue Shield promptly to our office. We can then submit the EOB for Blue Cross and the secondary insurance claim to the second company for additional payment. Failure to submit the Blue Cross Blue Shield Explanation of Benefit copy to us in a timely manner may result in finance charges.

All insurance companies send the Explanation of Benefits to our office and to the patient. Co-pays from the patient will be billed to the patient with our monthly billing statements. Statements will continue to be sent on a 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.

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 April 14, 2003, 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 Officer: Patricia Trahan Halbach
Telephone: 802-527-1227 Fax: 802-527-3767
E-mail: dbdcadmin@dbdentalcarevt.com
Address: 12 Mapleville Depot, 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).

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** Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

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.

_____

_____

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)

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

REQUEST FOR RELEASE
OF
MEDICAL RECORDS

TO:

_____
Doctor's name (Print)

_____
Address

_____ _____
City State Zip

I hereby request that my dental records be released to :

dickinsonbranon@dbdentalcarevt.com
or mail to:
Dickinson & Branon Dental Care
12 Mapleville Depot
St. Albans, Vermont 05478

_____
Patient Name (print)

_____
Patient Signature