bg Family Dentistry
Brad H. Green, D.D.S., P.A.

(479) 846-1005
401 East Buchanan
Prairie Grove, AR 72753

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient #_____
SS#/SIN_____
Date_____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address_____ City_____ State_____ Zip_____
Email_____ Cell Phone_____
Check Appropriate Box ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*
If Student, Name of School/College_____ City_____ State_____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian Employer_____ Work Phone_____
Business Address_____ City_____ State_____ Zip_____
Spouse or Parent/Guardian's Name_____Employer_____Work Phone_____
Whom May We Thank for Referring You?_____
Person to Contact in Case of Emergency_____ Phone_____

RESPONSIBLE PARTY

Name of Person Responsible for this Account_____ Relationship to Patient_____
Address_____ Home Phone_____
Email_____ Cell Phone_____
Driver's License # _____ Birthdate_____ Financial Institution_____
Employer_____ Work Phone_____ SS#/SIN_____
Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ *Cash* ☐ *Personal Check* *Credit Card* ☐ *Visa* ☐ *Mastercard* ☐ *I wish to discuss the office's payment policy.*

INSURANCE INFORMATION

Name of Insured_____ Relationship to Patient_____
Birthdate_____SS#/SIN_____ Date Employed_____
Name of Employer_____ Union or Local#_____Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group#_____ Policy ID#_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____
Birthdate_____SS#/SIN_____ Date Employed_____
Name of Employer_____ Union or Local#_____Work Phone_____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Group#_____ Policy ID#_____
Ins. Co. Address_____ City_____ State_____ Zip_____
How Much is your Deductible?_____ How Much Have You Used?_____ Max. Annual Benefit_____

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PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any allergic reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____	☐	☐

10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems with your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) **X**_____

Doctor's Comments _____

_____

_____ Signature _____ Date _____

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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 the 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 (04/14/03), 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 changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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.

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for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use or disclosure 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 health care or with payment for your health care, 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 you care, of you 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 you health care. 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 require 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, or 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 voice mail 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expense such as copies and staff time.

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You may also request access by sending us a letter to the address at the end of this Notice. If you prefer we will prepare a summary or an explanation of your health information. Contact us using the information listed at the end of this Notice for a full explanation.

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, health care operations and certain other activities for the last 6 years, but not before October 1, 2007. 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.

Restrictions: 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 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

PLEASE INITIAL ON THE LOWER RIGHT CORNER OF ALL THREE PAGES

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WELCOME TO OUR PRACTICE

Please read over this document carefully. If you have any questions, please ask the receptionist before seeing the doctor.

OFFICE POLICY

If you have insurance, we will be happy to file on your behalf. All deductables and co-payments are due at the time services are rendered. We are PPO providers for Delta Dental, Blue Cross Blue Shield, Cigna, Met Life, GEHA, United Health Care, and Guardian. If this office is a provider on your plan we will estimate your portion at the end of each appointment. This is an estimate and no guarantee that insurance will cover all procedures. Due to the variation in dental plans there is a possibility that after the claim is paid there will be a balance for services not covered in some plans. We will notify you by phone or letter when the claim is processed and the balance is calculated. Payment will be expected at that time. All insurance claims not paid within 45 days will become the patient's responsibility.

If we are not providers for your insurance, you will be required to pay in full at time of service. We will file your claim and your insurance will reimburse you for the expense.

We do not offer an in house payment plan. Payment is due at the time of service. We accept cash, check, Visa, MasterCard, and Care Credit. We cannot accept post dated checks as this is a violation of Arkansas hot check laws. If an account is unpaid after 60 days the account will be turned over to a collection agency.

POLICY FOR FAILED APPOINTMENTS

We understand that there will be circumstances where you will have to reschedule your appointment. We ask for 24 hours notice to allow us to give the time to another patient. You may call us or leave a message on voice mail. Failure to give 24 hours of notice will result in a $35.00 charge.

Please sign below stating that you have read, and understand the policies of this office.

Patient signature	Signature of guardian/responsible party
Date	Date
Print name	Print name