Blue River Dental

PATIENT First Name_____ Last Name:_____ Middle Initial _____

Preferred Name_____ Date of Birth _____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone_____

Sex: Male OR Female **Marital Status**: Married Single Divorced Separated Widowed

Social Security Number_____ Driver's License Number _____

Email Address: _____

****** **IF PATIENT IS A MINOR - PARENT / GUARDIAN INFORMATION** *****

FIRST_____ _____ LAST _____ Date of Birth _____

Sex: Male OR Female **Marital Status**: Married Single Divorced Separated Widowed

Social Security Number_____ Driver's License Number _____

INSURANCE INFORMATION Person who carries Insurance _____

Employer who carries Insurance_____ Date of Birth_____

Insurance Company Name_____ Phone Number _____

Insurance Company Address_____

Subscriber or Member Number _____ Social Security Number _____

Policy Number _____ Group Number _____

Secondary Ins_____

Information Release

Blue River Dental Care requires our staff to obtain authorization from the patient to leave a detailed message for our patients. This is Secondary to the New HIPAA guidelines; we must guard against violating any patient confidentiality and, protect our staff.

By signing below, I give my consent to Blue River Dental to leave messages regarding my care and or upcoming appointments on my home or personal cell phone.

Signature_____ Date_____

EXPRESS CONSENT TO COMMUNICATION

The undersigned ("you" or "your") hereby gives express consent for Blue River Dental Care, P.C. ("creditor") to contact you at the phone numbers and emails listed below in connection with your business relationship with creditor. The term "contact" includes landline and cellular telephone communications, leaving voice mails or answering machine messages, leaving messages with persons who answer phones authorized by you, text message communications, email message communications, and similar methods of communication. This express consent also authorizes such communications to be sent by automated dialers and messaging equipment. This express consent also applies to any phone numbers and emails you provide in the future whether you provide such phone numbers and emails in writing or verbally. This express consent also allows any agents, contractors, or attorney of creditor to contact you at the phone numbers or emails you provide to creditor for the purpose of resolving any unpaid balances owed to creditor. You may cancel this consent at any time by notifying creditor or, if applicable, by notifying an agent, contractor, or attorney of creditor that is in current contact with you.

_____

Signature Date

_____

Printed Name

Authorized Phone Numbers_____/_____/_____

Authorized Email_____

FINANCIAL CONSENT

The undersigned herby authorize Blue River Dental Care doctors or staff member to take all necessary radiographs, study models, photographs, or any other diagnostic aids required to make a thorough diagnosis of existing conditions. I authorize BRDC to share my Protected Health Information (PHI) with other health care providers if being referred for treatment, which includes verbal, written or electronic communications. I understand the responsibility for the payment of dental services provided in this office for my dependents or myself is mine, due and payable at the time of services rendered. I authorize use of my PHI to submit dental claims and understand that insurance will be filed as a courtesy. Estimations are based on information from my insurance company. The estimate is not a guarantee of payment. Regardless of financial arrangements the full responsibility for payment is mine. I further understand that any collection or attorney fees may be added to any overdue balance. I also assign all insurance benefits to Blue River Dental Care. I agree to pay any balance or copay at time of service. If my insurance company sends payment to me directly I understand that I may be asked to pay my balance in full prior to treatment being rendered. I understand any financial arrangements must be made PRIOR to scheduling an appointment for treatment, and a deposit of up to 50% of the treatment fee may be required. I understand that a 1.5% finance charge per month (18% annually) may be added to my account for any balance over 90 days, regardless of any pending insurance claims. I understand that I am responsible for any fees / costs that may be incurred for the collection of my account (e.g., collection agency fees, court costs, and attorney fees).

PATIENT Signature OR Parent if Minor _____Date ____/____/____

Blue River Dental Care, P.C.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____ DOB:_____

Address:_____

Phone:_____ Email:_____

Dependent children Names:_____

Drivers License Number: _____

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 of care out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices 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.

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 protected health information that we maintain.

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

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 action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent for, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient:_____

Notice of Privacy Policy : http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.pdf

Blue River Dental Care, P.C.

Patient Name: _____ Date:_____

Our practice is committed to providing each or our patient with individualized comprehensive care consistent with their particular needs, wants and values. By answering the following questions candidly you will help us to better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1. What prompted you to contact our office for an appointment? _____

   _____

2. Does dental treatment make you nervous? No Slightly Moderately Extremely

3. Have you ever had any serious trouble associated with previous dentistry? Yes No

4. Do you use the following?

   Toothbrush Yes No How often?_____
   Dental Floss Yes No How often?_____
   Power Brush Yes No How often ?_____

5. Do you have or ever had any of the following?

   _____ Orthodontic treatment
   _____ Clicking / Popping jaw
   _____ Clenching or grinding
   _____ Loose teeth
   _____ Teeth sensitive to hot, cold, sweet
   _____ Teeth sensitive to chewing
   _____ Bleeding or sore gums
   _____ Unpleasant taste or bad breath

6. Do you Snore ? YES NO
7. On a scale 1 to 10 (10 being perfect) how healthy do you think your mouth is?_____
8. Are you happy with the appearance of your teeth? YES NO
9. Do you expect to keep your teeth for the rest of your life? YES NO
10. What are some questions about dentistry or your oral health that you have?_____

    _____