GETTING TO KNOW YOU

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NAME: _____ DATE: _____

What name would you like us to call you? _____

Please describe the reason for your consultation today:

_____

_____

_____

_____

How long has this been going on and what other events apply to today's visit?

_____

_____

Why have you decided to deal with this now?

_____

Have you consulted with any other dentist about this? ☐ Yes ☐ No If yes, what was discussed or done?

_____

_____

When was your last dental check up? _____

Who is your regular or previous dentist? _____

Have you noticed or has any dentist or hygienist ever said that you:

Have gum disease (gingivitis)	**☐ Yes ☐ No**	**Lip or cheek biting**	**☐ Yes ☐ No**
Grind your teeth	**☐ Yes ☐ No**	**Loose or broken teeth or fillings**	**☐ Yes ☐ No**
Clicking or popping jaw	**☐ Yes ☐ No**	**Food collection between teeth**	**☐ Yes ☐ No**
Jaw Pain or tiredness	**☐ Yes ☐ No**	**Sores, blisters or growths**	**☐ Yes ☐ No**
Pain around ear	**☐ Yes ☐ No**	**Bad Breath**	**☐ Yes ☐ No**

Sensitivity to: ☐ cold ☐ heat ☐ sweets ☐ when biting or chewing

Would you like to know your options to: ☐ Improve your smile ☐ Look younger ☐ Keep your teeth

What are your priorities and what would you like to see done now?

_____

_____

PERSONAL INFORMATION – HEALTH HISTORY

NAME:_____ ☐Male ☐Female Date: _____

DOB:_____SS#:_____ Marital Status: ☐Single ☐Married ☐Child

ADDRESS: _____City_____ZIP_____

Home Phone: _____ Work:_____ Cell:_____ E-Mail_____

OCCUPATION:_____ **EMPLOYER** & address_____

Insurance Carrier: _____ Insurance Phone# _____

Group# _____ ID# _____ Insurance Holder: ☐SELF ☐SPOUSE ☐ OTHER

Spouse's **NAME** _____ **EMPLOYER** & address_____

ACCOUNT RESPONSIBILITY if someone other than yourself:

Name: _____ Relationship: _____ SS# _____ DOB_____

Mailing Address:_____ Daytime Phone:_____

HEALTH HISTORY (please **CHECK and/or CIRCLE** if you have or have had any of the following)

☐Has your health changed in the last year

☐Chest pain, Shortness of breath

☐Stroke

☐Bleeding problems, bruise easily

☐Headaches, Ringing in ears

☐Joint Pain or Stiffness, Arthritis

☐Fainting or Seizures

☐Heart Disease, Murmurs, Rheumatic Fever,

☐Pacemaker, Prosthetic Heart Valve, Stint

☐High Blood Pressure

☐Hepatitis or Liver Disease

☐TB, Asthma, or Lung Disease

☐Tumors, Cancer

☐Diabetes

☐Pre Med Before Treatment

☐Radiation Treatment, Chemo

☐Psychiatric Care

☐Kidney or Bladder Disease

☐VD, Herpes

☐HIV Positive, AIDS, ARC

☐Pregnant: month due_____

☐Birth Control Pills

☐Recreational Drugs (ex: marijuana)

☐Tobacco/How Much_____

☐Alcohol Use/How much _____

☐Have any joint replacements

☐Thyroid problem

☐Ulcers/Reflux

☐Alzheimer's or Dementia

☐Other _____

List any and all **ALLERGIES**: _____

List any and all **DRUGS/MEDICATIONS** you are taking: _____

List any and all **SURGERIES** in the **last 5 years**: _____

Are you being treated by a Doctor now? Who? _____

To whom may we thank for your **referral** to our office? _____

I am aware that appointment cancellations less than 24 hours may be subject to a fee ($35)

The above information is true and correct to the best of my knowledge: ** Updated 6/12/2023

PATIENT SIGNATURE: _____ **DATE**: _____

INSURANCE POLICY & ASSIGNMENT OF BENEFITS

Effective January 1, 2007

Thank you for choosing us as your dental care provider. Our greatest concern is your complete oral health. Anything we say or do will be centered on that philosophy. We are committed to your treatment being successful and maintaining good oral health. Please understand that the payment of your bill is considered part of that treatment. The following is a statement of our INSURANCE POLICY, which we ask you to read and sign in acknowledgement.

By signing below, I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or child during the period of such Dental care to 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 and agree that my insurance company has rules and guidelines by which my claim may be paid or denied. I understand that I have a contract with my insurance company through my employer or individual plan and that I should know what to expect from my benefits. I further understand that Barry H. Buchanan, DDS does not have a contract with my insurance company and therefore cannot guarantee any coverage, benefits, and/or payments from my insurance company. The office of Barry H. Buchanan, DDS will attain information regarding my eligibility and benefits with my insurance company, file all claims, and accept assignment of benefits, however, since every insurance company plan pays differently on many services they cannot guarantee that the insurance company will pay as estimated. I also understand that my insurance company may determine benefits based on their own set fee schedules or maximum allowable fee schedules and that my insurance company will not share such information with the office of Barry H. Buchanan, DDS because he is not in contract with my dental insurance company. **We will not be responsible for filing Secondary Insurance**, you will pay the uncovered portion and file a claim with your secondary for reimbursement paid directly to you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Barry H. Buchanan, DDS.

I understand and agree that I am responsible for any co-pays, the estimated amount not paid by the insurance company, as well as any deductibles that may be inherent to my plan at the time of service.

I understand that after the insurance company pays Barry H. Buchanan, DDS there could still be a balance remaining, for which I am responsible. I agree to pay any unpaid balance in full within 30 days of being billed unless prior arrangements have been made in advance.

In addition to dental insurance, we accept cash, all major credit cards, and offer financing through Care Credit. For many patients, spreading payments out over several months fits perfectly into their budget. We will do our best to accommodate your needs and work with you to maximize your dental benefits and create a dental plan that works for you.

Printed Name _____ DOB _____

Signature _____ Date _____

FINANCIAL POLICY

(EFFECTIVE APRIL 1, 2005)

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PAYMENT FOR SERVICES RENDERED: Patients are responsible for payment of all services rendered on their behalf, or their dependants. Payment is due in full at time of service, unless previous arrangements have been made and are fully understood and agreed upon by both parties. Accounts will only be billed if balance is left from insurance claims not paid.

INSURANCE ASSIGNMENT: It is the patient's responsibility to know his/her own insurance coverage and benefits. You must notify us as soon as possible if your insurance or plan benefits have changed. We will accept assignment of insurance benefits and file your dental claims; but you are solely responsible for your account. If your insurance company has not paid your claim in 90 days, you will be responsible for your account balance in full.

INSURANCE FACTS: Most insurance plans cover only a percentage of the fees charged and may have a deductible, which must be satisfied before any insurance benefits will be paid. We require that all deductibles, co-pays, and/or any percentages of the bill that the PRIMARY insurance carrier does not cover, be paid at the time of service. Also, please keep in mind the provisions of your insurance plan may exclude certain procedures. The insurance company's exclusion of a procedure does not absolve the patient from responsibility for payment.

DEFAULT ON PAYMENT: In the event of default on payment, the patient, or guardian, promises to pay any and all collection costs and attorney fees as may be required to effect collection of this account.

I am aware that cancellations less than 24 hours may be subject to a fee ($35)

I have read and fully understand the above policy.

Patient(s) _____

Responsible Party Signature_____Date_____

Barry H. Buchanan, DDS
7115 Greenville Ave., Ste. 200
Dallas, TX 75231
214-343-1818

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPAA

You May Refuse to Sign This Acknowledgement

I, _____, have read and/or received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____

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.
- ☐ Communication barriers prohibited obtaining acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please specify):

_____

_____

_____