O'Fallon Family Dentistry & Smile Center
Dr. Steve Branham
126 Triad West Dr.
O'Fallon, Mo 63366

Payment Options Available for our Patients with Dental Benefits

...making quality care affordable

As you may be aware, many dental offices have begun to require patients to pay for their full treatment fee (including those portions covered by insurance) in advance. Patients then must wait for a check to arrive at home from their insurance company reimbursing them for any portion covered by insurance.

We do not want to inconvenience our patients in this way!

As a courtesy to you, for routine services we will estimate as best we can what your company's dental benefits will cover. We expect you to pay only your estimated portion at each appointment by either cash, check, Visa, or Mastercard.

Most insurance companies pay us within 45 days. In those rare situations where after 45 days we have not received payment from your insurance company, we must begin issuing billing statements to you at home for return payment by mail. We will provide you with all information and support to call and receive your remittance due from your insurance carrier.

Please read the following 3 statements and sign below indicating your agreement to these terms:

1. **I agree to be responsible for full payment of all services rendered on my behalf or my dependents.**
2. **I understand that the limitations of my dental benefits may result in less than full coverage of the actual bill for services.**
3. **Regardless of my dental benefits, I understand that I am financially responsible for full payment of all accounts. By signing this statement, I revoke all previous agreements to the contrary.**

_____ _____

Signed Date

If after your initial visit it is determined that more extensive treatment is desired, we have many flexible payment options available to assist you in financing your treatment. Please speak with our financial coordinator if you are interested in learning more about these options.

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Family Dentistry

WELCOME

In order to ensure your maximum oral health and allow us to prescribe the proper medications, it is very important that we know all medical and dental information about you. Please check every box on the front and back of this form, even if the answer is "N/A" (not applicable). This information will be kept In the Strictest confidence.

You also should know that changes in other parts of your body may~ affect the oral cavity and what dental treatment can be done, even if they seem unconnected. Cardiac (heart) problems, artificial joints and diabetes are just some examples.

Will you Please inform the dentist or the staff at the beginning of each new office visit if your medical or dental conditions have changed since we last saw you? Yes ☐ No ☐. Thank you.

1 Patient Information

Date _____

Patient _____

Address _____

_____

City State Zip

I prefer to be called: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other

Birthdate _____ Gender: F ☐ M ☐ Age ____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____ - _____ - _____

If patient is a minor, give parent's or guardian's name:

_____

Occupation _____

Spouse's Name _____

Spouse's Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 Dental Insurance

Who is responsible for this account? _____

Who is the subscriber for this insurance? _____

Subscriber place of employment? _____

SS# _____ - _____ - _____ Birthdate _____

Relationship to Patient: _____

Insurance Co. _____

Group #. _____

Is patient covered by additional insurance? Yes ☐ No ☐

Subscribers Name: _____

Insurance Co. _____

Group #. _____

3 Phone Numbers

Home Phone _____

Work _____ Ext. _____

Cell Phone # _____

Spouse's Work _____

Best time and place to reach you: _____

Family Physician's Name: _____

Physician's Phone: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____

Relationship _____

Home Phone _____

Work Phone _____

4 ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as indicated and assign directly to this office all insurance benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship to Minor (if applicable) Date

WELCOME

5 Dental History

Reason for today's visit _____

_____

Former Dentist _____

Date of last dental visit _____

Date of lad dental x-rays _____

Mark "Yes" or "No" to indicate if you presently have or previously had any of the following:

Bad Breath Yes ☐ No ☐
Bite your lips or cheeks regularly Yes ☐ No ☐
Bleeding gums Yes ☐ No ☐
Blisters on lips or mouth Yes ☐ No ☐
Chew on one side of mouth Yes ☐ No ☐
Dry mouth Yes ☐ No ☐
Food collection between the teeth Yes ☐ No ☐
Grinding teeth Yes ☐ No ☐
Gums swollen or tender Yes ☐ No ☐
Jaw pain or tiredness Yes ☐ No ☐
Mouth breathing Yes ☐ No ☐
Orthodontic treatment Yes ☐ No ☐
Pain around ear Yes ☐ No ☐
Periodontal (gum) treatment Yes ☐ No ☐
Sensitivity to cold Yes ☐ No ☐
Sensitivity to hot Yes ☐ No ☐

Have you experienced.

Clicking or popping of the jaw? Yes ☐ No ☐
Pain? (Joint, ear, side of face) Yes ☐ No ☐
Difficulty in opening or closing the mouth? Yes ☐ No ☐

How often do you floss?_____

How often do you brush?_____

Do you require antibiotics before dental treatment? Yes ☐ No ☐

Are you currently In pain? Yes ☐ No ☐

Have you aw had a serious / difficult problems associated with any previous dental work? Yes ☐ No ☐

Do you like your smile? Yes ☐ No ☐

Do you feel nervous about having dental treatment? Yes ☐ No ☐

Have you ever had a bad experience in a dental. office? Yes ☐ No ☐

If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

_____

_____

6 Medical History

Your current physical health is:
Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐

Please explain: _____

_____

Are you taking any prescription / over the counter drugs? Yes ☐ No ☐

Please list each one _____

_____

_____

_____

_____

_____

Do you smoke or use tobacco in any other forms? Yes ☐ No ☐

For Women:

Are you taking birth control pills? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Are you nursing? Yes ☐ No ☐

Do you have or have you ever had any following diseases or medical problems?

Abnormal Bleeding Yes ☐ No ☐
Alcohol / Drug Abuse Yes ☐ No ☐
Alzheimer's Disease Yes ☐ No ☐
Anemia Yes ☐ No ☐
Arthritis Yes ☐ No ☐
Artificial Bones Joints Valves Yes ☐ No ☐
Asthma Yes ☐ No ☐
Blood Transfusion Yes ☐ No ☐
Bruise Easily Yes ☐ No ☐
Cancer / Chemotherapy Yes ☐ No ☐
Colitis Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Difficulty Breathing Yes ☐ No ☐
Emphysema Yes ☐ No ☐
Epilepsy Yes ☐ No ☐
Fainting Spells Yes ☐ No ☐
Frequent Headaches Yes ☐ No ☐
Glaucoma Yes ☐ No ☐
Hay Fever Yes ☐ No ☐
Heart Problems Yes ☐ No ☐
Heart Murmur Yes ☐ No ☐
Hemophilia Yes ☐ No ☐
Hepatitis Yes ☐ No ☐
Herpes/Fever Blisters Yes ☐ No ☐
High Blood Pressure Yes ☐ No ☐
HIV+ / AIDS Yes ☐ No ☐
Hospitalized for Any Reason Yes ☐ No ☐
Joint Replacement Yes ☐ No ☐
Kidney Problems Yes ☐ No ☐
Liver Disease Yes ☐ No ☐
Low Blood Pressure Yes ☐ No ☐
Mitral Valve Prolapse Yes ☐ No ☐
Nervous/Anxious Yes ☐ No ☐
Pacemaker Yes ☐ No ☐
Psychiatric/Psychological Care Yes ☐ No ☐
Radiation Treatment Yes ☐ No ☐
Rheumatic/Scarlet Fever Yes ☐ No ☐
Seizures Yes ☐ No ☐
Sinus Problems Yes ☐ No ☐
Stroke Yes ☐ No ☐
Thyroid Problems Yes ☐ No ☐
Tuberculosis (TB) Yes ☐ No ☐
Tumors or Growths Yes ☐ No ☐
Ulcers Yes ☐ No ☐
Venereal Disease Yes ☐ No ☐

Do you have or have you had any disease, condition, or problem not listed? Yes ☐ No ☐

Are you allergic to any of the following?

Aspirin Yes ☐ No ☐
Codeine Yes ☐ No ☐
Dental Anesthetics Yes ☐ No ☐
Latex Yes ☐ No ☐
Metals Yes ☐ No ☐
Penicillin Yes ☐ No ☐
Tetracycline Yes ☐ No ☐

Please list any other drugs/materials that you are allergic to: _____

_____

_____

_____

_____

7

CERTIFICATION: I certify that the answers given are correct to the best of my knowledge.

_____ _____

Signature Date