Star City Family Dentistry

MEDICAL HISTORY

PATIENT NAME ______________________________ Birth Date ____________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: ____________________

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: ____________________

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No ____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No ____________________

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: ____________________

Do you have, or have you had, any of the following?

Condition	Yes / No	Condition	Yes / No	Condition	Yes / No	Condition	Yes / No
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problem	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No ____________________

Comments: ______________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ____________

PATIENT REGISTRATION FORM

Adult				Child	
Name		Social Security Number		Name	Social Security Number
Spouse		Social Security Number		Parents Name	
Address				Address	
City	State	Zip		City	State / Zip
Home Phone		Business Phone		Home Phone	
Date of Birth		Age		Date of Birth	Age
Married	Single	Divorced	Widowed	School	

Getting to Know You	Dental Insurance
Patient's Employer	Primary Carrier
Present Position	Subscriber Name
How Long Held	Subscriber Date of Birth
Business Address	Secondary Carrier
Spouse's Employer	Subscriber Name
Present Position	Subscriber Date of Birth
How Long Held	In Case of Emergency
Purpose of Call	Name
Referred by	Phone Number

Account Information			
Who Will Pay This Account	Bank		
Address	City	State	Zip

Financial Policy

I understand that I am responsible for payment for all services rendered. In the event my account becomes delinquent or remains unpaid over 90 days from the date of service, I will be responsible for interest at the rate of 18% from the date of service on the outstanding principal balance. If my account is forwarded to an attorney for collection, I will be responsible for an attorney fee of 35% of the principal balance due at the time the account is turned over.

Signature ____________________ Date ____________

HIPAA Notice of Privacy Practices

Jeannene Bradley, DDS (Name)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

- -

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:______________________ Signature________________ Date____

Star City Family Dentistry, Inc.

Appointment Policies

An appointment on our schedule is a bond of trust that we will be here to serve you, and you will be present for treatment. Star City Family Dentistry, Inc. does not double book appointments. This allows us to give you our full attention at your appointment. Our office policy is firm in this regard, and we will not tolerate frequent cancellations, constant short-notice changes or tardiness. We must have mutual respect for each other's time. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. We will not be able to treat patients who have a history of missed/cancelled appointments or are late without valid reasons.

ALL minors under the age of 18 are REQUIRED to have a parent/legal guardian (in cases of children of divorced/separated parents) present during the appointment, unless an authorization for minor child accompany form has been signed by parent or legal guardian. If an authorization for minor child accompany form is being utilized the person being authorized to bring the child must be 18 or older.

As a courtesy, our staff attempts to confirm appointments two days before the appointments scheduled date and time. However, it is ultimately your responsibility to keep your appointment and be on time, even if we have not been able to contact you. We also ask that you arrive 10 minutes prior to your appointment time in order to update any personal information, insurance changes and to pay any patient portion of treatment that may be due at that time. The appointment time is the actual time that you should be seated and prepared for treatment.

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give 24 hour notice to reschedule or cancel any appointment. This will allow us time to offer the newly available appointment slot to other patients. While we understand that unforeseen circumstances occur, we just ask that you please respect the time that we have reserved just for you.

Star City Family Dentistry, Inc. allows for one failed appointment before a $75.00 reschedule fee is required. Broken appointment fees are applied to each individual appointment that is failed. For example if you have a family with multiple appointments failed, each family member will incur a broken appointment fee.

If you arrive 10 minutes late for a hygiene appointment you will be required to reschedule that appointment. Every subsequent time that you arrive 10 minutes late you will be required to reschedule the appointment and pay a $75.00 reschedule fee.

If you arrive 10 minutes late for an appointment with Dr. Bradley, treatment may be altered to perform another treatment in the remaining time of the appointment or you may be asked to reschedule the appointment. Every subsequent time that you arrive 10 minutes late and an alternate treatment cannot be performed, in the time remaining, you will be required to pay a $75.00 reschedule fee.

If you call the office stating that you are on your way, and it is already your appointment time or into your appointment time, you will be asked to reschedule the appointment. You can do this while you are on the phone, or you can call back to reschedule. If you have failed previously or have cancelled with less than 24 hour notice previously, you will be charged the $75.00 reschedule fee.

For established patients, if three failed appointments occur, our office reserves the right to NOT schedule any subsequent appointments, and you will be dismissed from the dental practice.

New patients will NOT be accepted into the dental practice, if they fail to show or cancel without proper 24 hour notice for the initial new patient appointment.

All NEW PATIENTS must confirm their first three appointments after their initial appointment in order to establish themselves as responsible patients. If they fail to confirm the first restorative appointment, then ALL future appointments will be cancelled. This will be considered their first failed appointment without being charged a $75.00 reschedule fee. If they do reschedule after failing their first appointment they must confirm the first three appointments. The second time that they fail, ALL future appointments will be cancelled, and they will need to pay a $75.00 reschedule fee. If they fail a third time they will be dismissed from the dental practice.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask.

I have read and understand this document in its entirety; outlining the office appointment policies of Star City Family Dentistry, Inc.

____ ____________

Patient signature or (Parent/ Legal Guardian if minor) Date

____ ____________

Witness of Star City Family Dentistry, Inc. Date

Star City Family Dentistry, Inc.

Financial Agreement

Since we are a dental provider for most insurance carriers, we will submit your insurance claims for you. However, your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for any co-payment (patient portion of percentage not covered by insurance carrier) and deductibles. Due to the constantly changing insurance contracts, benefits and deductibles, we are only able to estimate your insurance coverage. Although we estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusion, and waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

Payment for co-payments/deductibles or other charges are due at the time of service. We accept cash, checks, Visa, Master Card and American Express

Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance carrier if this applies to you.

There are many factors in determining patient responsibility where coordination of benefits between two insurance carriers are involved. We will provide you with the most accurate information available to us but CANNONT guarantee what your out of pocket expense will be.

All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance carrier 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. If the balance is not paid by the due date on the statement then all future appointments will be cancelled until balance is paid. It is the responsibility of the account holder to follow up with their own insurance carrier regarding the non-payment of the claim, (our office will try and assist you to the best of our ability if needed). Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past due accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge 1.5% per month, from the date of service, until the account is paid in full. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees. These collection fees will be added to the outstanding portion of the account and will also become the financial responsibility of the account holder. If your account is sent to collections, the patient and any patients connected to the account, will be dismissed from the practice and will not be accepted back into the practice.

Patients that do not have insurance are required to pay the entire amount of treatment charges at time of treatment and will receive a 5% discount.

I understand my financial obligation as outlined above. I am aware that any balance outstanding after sixty (60) days is my responsibility and if it is due to an insurance matter, I am responsible for resolving the issue.

_______________________________ ____________

Patient/Responsible Party Signature Date

_______________________________ ____________

Witness for Star City Family Dentistry, Inc. Date

OUR OFFICE NOW UTILIZES AN AUTOMATED SYSTEM TO CONTACT OUR PATIENTS. PLEASE ENSURE THAT OUR OFFICE HAS YOUR CELL PHONE TELEPHONE NUMBER AND E-MAIL ADDRESS.

AFTER OCTOBER 1, 2018, WE WILL NO LONGER MAKE "REMINDER" TELEPHONE CALLS OR SEND RECALL POSTCARDS TO PATIENTS.

THIS NEW SERVICE ALSO ALLOWS YOU TO MESSAGE US BACK DURING THE DAY WHEN YOU MAY NOT BE ABLE TO GET THROUGH ON OUR TELEPHONE LINES.

PLEASE ALSO NOTE THAT WE CAN CUSTOMIZE YOUR PREFERENCES AT TO FREQUENCY OF YOUR AUTOMATED REMINDERS.

WE APPRECIATE YOUR ASSISTANCE AND PATIENCE WHILE WE START UTILIZING THIS NEW SYSTEM.

PATIENT NAME: ______________________________

EMAIL ADDRESS: ____

CELL PHONE NUMBER: _________________________

COVID-19 PANDEMIC NOTICE AND ACKNOWLEDGEMENT OF RISK

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Ou practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment durin this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, no show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in som patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by othe dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk o you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protectiv mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth t render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulation and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at al times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

______________________________ __________

Patient or Legal Representative Signature Date

____

Print Patient or Legal Representative Name/Relationship

__________________________ __________

Witness Signature (optional) Date

Revised May 8, 2020

Patient Screening Form

ADA®

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.