Branson Family Dentistry

NEW PATIENT INTAKE FORM

DATE: _____

- **Patient Name: _____**
- **Birthday: _____**

- **Patient's Address: _____**
- **City: _____State: _____Zip: _____**
- **Best phone number to be reached at: Home _____**
  Cell _____
- **Parent's Name - If under 18 years of age or still under parent's care:**
  _____

- **Dental Insurance: YES ___ or NO ___**
- **Name of Insurance: _____**
- **Insurance Address: _____**
- **Policy Holder Name: _____**
- **Policy Holder Date of Birth: _____**
- **Policy Holder ID Number: _____**
- **Employer: _____**
- **Group Number: _____**

OUR OFFICE IS COMMITTED TO HELPING OUR PATIENTS MAXIMIZE THEIR INSURANCE BENEFITS. AS A COURTESY TO YOU WE WILL SUBMIT ALL INSURANCE CLAIMS.

****THE PATIENT ESTIMATED PORTION OF YOUR BILL MUST BE PAID AT THE TIME OF SERVICE. ANY OUTSTANDING BALANCE AFTER THE INSURANCE REIMBURSEMENT FOR SERVICES WILL BE YOUR RESPONSIBILITY TO PAY.**

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?

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 _____

Branson Family Dentistry

Thank you for choosing Branson Family Dentisty & Orthodontics for all your dental needs. We are committed to providing you with excellent care. Our office and financial policies are outlined below and are based on an open and honest discussion of recommended treatment options and respective fees.

PAYMENT

Payment is due in full at the time of services. We offer several payment options including:

- Cash, Checks, Visa, Mastercard, Discover, and American Express
- CareCredit
- Proceed Finance
- Cherry Financing

Please initial _____

INSURANCE

Our office is committed to helping our patients maximize their benefits, and as a courtesy to you, we will submit your insurance claims, with the exception of Adult Medicaid and Medicare. As you may be aware, medical and dental insurance is becoming increasingly complex. We are always available to answer your questions, however, your insurance policy is a contract between YOU and YOUR INSURANCE COMPANY, and as a dental service provider, we are NOT PARTY to that agreement.

We will submit insurance claims for you, however the patient **ESTIMATED** portion of your bill must be paid at the time of service. We ask that our patients provide us with COMPLETE dental insurance information. As a service to you, we will bill your insurance company for services and will allow 45 days to render payment in full. **AFTER 60 DAYS, YOU ARE RESPONSIBLE FOR THE ENTIRE BALANCE WHICH IS DUE IN FULL UPON REQUEST**. Insurance policies vary considerably, therefore, we try to ESTIMATE your coverage in good faith, but cannot GUARANTEE COVERAGE OR PAYMENT AMOUNTS by your insurance company. **THIS IS AN ESTIMATE ONLY**.

Please initial _____

MINORS

Payment of service for treatment of minors is the responsibility of the adult accompanying that minor at the time of service unless prior arrangements are made.

Please initial _____

MISSED APPOINTMENTS

Once you have made an appointment, please remember that this time has been reserved specifically for you. We are aware how important your time is and we ask that should you need to change an appointment that you kindly give a 48-hour notice. **We do reserve the right to charge a cancellation fee of $50.00 if no notice is given.**

Please initial _____

SERVICE CHARGES

It is the policy of this office to charge a 1.5% (18% annual percentage rate) fee with the minimum $2.00 to all accounts that are over 60 days past due.

We will charge a fee of $35.00 for each returned or unpaid check.

Please initial _____

FINANCIAL CONSENT

The patient or person responsible for the account agrees to be fully responsible for total payment of treatment performed in this office.

Please initial _____

COLLECTION FEE

We try our best to minimize the use of outside sources to aid in the collection of fees incurred in our office, however on some occasions it is necessary to utilize a collection company. Any account that is 60 days past due may be scheduled for collection. If an account is referred to a collection agency for retrieval of payment, any discounts/or previous professional adjustments given will be forfeited by the patient and these monies will be added back onto the account. In addition, all expenses relating to such collection will be charged to the person with financial responsibility for the patient's account. The minimum fee charged for collection of an account is $25.00.

Please initial _____

ELECTIVE SERVICES

Our office serves as an in-network participating provider with Delta Dental, Aetna, BCBS of WV. However, for major services (crowns, bridges, complete or partial dentures), an additional lab fee will be charged to cover the lab expenses. You are responsible for this cost. If you choose an elective cosmetic service and your insurance downgrades the service, you are responsible for this cost.

Please initial _____

I fully understand and agree to all the terms in this office policy.

Names of patients that are the responsibility of the signer. (PLEASE PRINT)

_____ _____

_____ _____

Signature of patient (or if minor, responsible party) _____Date _____

HIPAA Notice of Privacy Practices

Notice of Privacy Practices

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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Branson Family Dentistry. "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Branson Family Dentistry's Privacy Official at:

313 Courthouse Rd
Princeton WV, 24740
Telephone: 304-425-3050
Fax: 304-425-3038
bransonfamilydentistrywv@gmail.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on October 12, 2020.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health

information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If

you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is 10/12/2020.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Branson Family Dentistry & Orthodontics

313 Courthouse RD

Princeton WV 24740

304-425-3050

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Branson Family Dentistry *HIPAA Notice of Privacy Practices*.

I understand that Branson Family Dentistry *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Branson Family Dentistry revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Branson Family Dentistry *HIPAA Notice of Privacy Practices*, I may contact Branson Family Dentistry 304-425-3050.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Branson Family Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Branson Family Dentistry privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Branson Family Dentistry noted above, for assistance.

_____ Patient Signature

_____ Date

_____ Signature of Personal Representative

_____ Print Name of Personal Representative

_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Branson Family Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Branson Family Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

COVID-19 Coronavirus Questionnaire

Dear Patient,

In the interest of the safety and well-being of all patients and staff, we are requesting the following information to determine a relative risk of Coronavirus infection, and subsequent risk of transmission to others. Thank you for your cooperation in this time of uncertainty.

Please check ***yes*** or ***no*** for the following questions below:

1. Have you recently traveled to an area with known local spread of Coronavirus?

_____Yes _____No If yes or unsure, Where?_____.

2. Are you aware of having come into close contact (within 6ft), within the past 14 days, with someone who now has a laboratory confirmed Coronavirus diagnosis?

_____Yes _____No

3. Have you recently had a fever (greater than 100.5F or 38.0C) ***or*** developed symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing?

_____Yes _____No

Name: _____

Signature:_____ Date: _____

SUPPLEMENTAL INFORMED CONSENT

DENTAL TREATMENT IN THE ERA OF COVID-19

Thank you for your continued trust in our practice. As with the transmission of any Communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or any place. Be assured that we have always followed state and federal Regulations and recommended universal personal protection and disinfection protocols to limit Transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is Still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, dental health care providers, staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ No _____

_____ _____

Patient/Parent's Signature Date