Ballou Dental Arts Patient Information

Patient Information

Date: _____ Patient's Name:_____

Address:_____City_____ZipCode_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____ Social Security #: _____

How did you hear about our office?: _____

Emergency Contact: _____ Phone: _____

Responsible Party Information

Name: _____

Home Address: _____

Mailing Address (if different from above): _____

_____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Email Address: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Employer's Address _____

Occupation: _____ Group ID:_____ Subscriber ID: _____

Dental Benefit Company: _____ Dental Benefit Company Phone: _____

Dental Benefit Company Address: _____

Payment Responsibility

For our patients without dental benefits… I understand that all responsibility for dental services provided in the office for myself or my dependents is mine, due and payable at the time services are rendered.

For our patients with dental benefits… I understand that all services and fees may not be fully covered by an insurance carrier. I understand that I am ultimately responsible for payment of **all** dental services provided in this office for myself or my dependents. My co-payment is due and payable at the time services are rendered. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days. I authorize the use of my name on dental claims for services provided to me and my dependents. I authorize the payment of claims to this office.

If it becomes necessary to enlist a collection agency, the responsible party agrees to pay all costs of collection.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient Signature: _____ Date: _____

Parent or Responsible Party: _____Relationship to Patient:_____

BALLOU DENTAL ARTS
DENTAL AND MEDICAL HISTORY

Patient Name _____ Date _____

Primary reason for this dental appointment ☐ Examination ☐Emergency ☐Consultation

Dental History

	Please Circle	
Do you have a specific dental problem?	Yes	No
Do you have dental examinations on a routine basis?	Yes	No
Do you think you have active decay or gum disease?	Yes	No
Do you brush and floss on a routine basis?	Yes	No
Do your gums ever bleed?	Yes	No
Do you like your smile?	Yes	No
Does food catch between your teeth? Any loose teeth?	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint?	Yes	No
Have your past experiences in a dental office always been positive?	Yes	No
Do you smoke or chew tobacco?	Yes	No

Name of previous dentist (optional)_____

Date of last full mouth x-rays (16 small films or panoramic)_____

Medical History

	Please Circle	
Are you under a physician's care now?	Yes	No
Have you ever been hospitalized or had a major operation?	Yes	No
Have you ever had a serious injury to your head or neck?	Yes	No
Are you on a special diet?	Yes	No
Are you ☐ pregnant/ trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives	Yes	No
Are you allergic to any medication, food or substance? Please check box below	Yes	No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex Rubber

Other Allergies:

Are you taking any medications, prescription or over the counter? Please list below

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

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Trouble/Disease	□	□	Sickle Cell Disease	□	□	Frequent Diarrhea	□	□	Cold Sores	□	□
Heart Murmur	□	□	Leukemia	□	□	Diabetes	□	□	Fever Blisters	□	□
Irregular Heartbeat	□	□	Hemophilia	□	□	Hypoglycemia	□	□	Herpes	□	□
Angina/ Chest Pain	□	□	Swelling of Limbs	□	□	Liver Disease	□	□	Stroke	□	□
Heart Attack/ Failure	□	□	Lung Disease	□	□	Hepatitis A (infectious)	□	□	Convulsions	□	□
Mitral Valve Prolapse	□	□	Breathing Problem	□	□	Hepatitis B (Serum)	□	□	Epilepsy or Seizures	□	□
Scarlet Fever	□	□	Shortness of Breath	□	□	Hepatitis C	□	□	Fainting or Dizziness	□	□
Rheumatic Fever	□	□	Frequent Cough	□	□	Kidney Problems	□	□	Glaucoma	□	□
Artificial Heart Valve	□	□	Sinus Trouble	□	□	Renal Dialysis	□	□	Tumors or Growths	□	□
Pacemaker	□	□	Asthma	□	□	Thyroid Disease	□	□	Phychiatric Care	□	□
Heart Surgery	□	□	Emphysema	□	□	Arthritis/ Gout	□	□	Alzheimer's Disease	□	□
High Blood Pressure	□	□	Tuberculosis	□	□	Rheumatism	□	□	Seasonal Allergies	□	□
Low Blood Pressure	□	□	Cancer	□	□	Pain in Jaw Joints	□	□	Hives or Rash	□	□
Blood Disease	□	□	Radiation Treatments	□	□	Artificial Joint	□	□	Drug Addiction	□	□
Bruise Easily	□	□	Chemotherapy	□	□	Venereal Disease	□	□	Recent Weight Loss	□	□
Anemia	□	□	Stomach Disease	□	□	AIDS	□	□		□	□
Escessive Bleeding	□	□	Ulcers	□	□	HIV Positive	□	□		□	□

Have you ever had any other serious illness not checked above? Discuss _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in health status or if my medicines change, I shall inform the dentist and staff at the next appointment.

_____ Date_____

Patient Signature (Parent or Guardian)

Reviewed by Doctor _____ Date _____ BP _____/_____

Ballou Dental Arts
Consent for Treatment

1. I hereby authorize and direct the dentist(s) of Ballou Dental Arts and/or dental auxiliaries of his/her choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

    A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
    B. Application of plastic "sealants" to the grooves of the teeth.
    C. Treatment of diseased or injured teeth with dental restoratives (fillings and crowns)
    D. Replacement of missing teeth with dental prosthesis (bridges, partial dentures, full dentures).
    E. Removal (extractions) of one or more teeth.
    F. Treatment of diseased or injured oral tissues (hard and/or soft).
    G. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.

2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have an opportunity to ask questions regarding the treatment and risks, and that I fully understand the same.
3. I agree to the use of local anesthesia, nitrous oxide/oxygen analgesia, sedative drugs, physical restraints or voice control depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves and indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. I recognize during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks, such as, unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
6. I also authorize the doctor(s) to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications
7. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parent follow post-operative and post care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions to be followed and that regular office visits by my dentist and his/her auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner, and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
9. I further understand that this consent will remain in effect until such a time that I choose to terminate it.

Date:_____ Time: _____AM / PM File No. _____

Patient's Name: _____

Name of Parent or Guardian: _____Relationship to Patient: _____

Witness: _____

BALLOU DENTAL ARTS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/2006), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMAITON
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in you healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we wil charge you $0.25 for each page, $18.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we make about access to your health information or in response to a request you make to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Mindy Haynes
Telephone: 949-830-2355 Fax: 949-830-2352 Email: Mindy@balloudentalarts.com
ddress: 27462 Portola Parkway Suite 205, Foothill Ranch, California 92610

BALLOU
DENTAL ARTS

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

You may refuse to sign this acknowledgment

I, _____, have read and received a copy of the Ballou Dental Arts Notice of Privacy Practices.

Signature: _____ Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgment
___ An emergency situation prevented us from obtaining the acknowledgment
___ Other (please specify) _____

PHOTO CONSENT

I, _____, give Ballou Dental Arts consent to use my photo to post in the office for the purpose of patient recognition, patient education or internal marketing.

If patient is a minor, consent must be signed by a guardian.

Name of guardian: _____

Relationship to patient: _____

Signature: _____ Date: _____

BALLOU
DENTAL ARTS

REQUEST FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby grant permission to

_____ to release information related to my health history, status, and treatment, copies of my health record, X-rays and any test results to:

Ballou Dental Arts
27462 Portola Parkway, Suite 205
Foothill Ranch, CA 92610
(949) 830-2355

NAME OF PREVIOUS DOCTOR _____

ADDRESS _____

_____

SIGNATURE: _____ DATE: _____
(IF A MINOR, PARENT OR GUARDIAN MUST SIGN)

DENTAL MATERIAL FACT SHEET

I, _____ have received a copy of the dental material fact sheet.

Signature:_____ Date:_____