W. Blake Bybee, DDS

Welcome to our practice! At Hidden Springs Dental we are committed to providing the highest standard of care while treating your dental needs. We strive to understand your needs, tailor treatment specifically to each individual patient, and to exceed expectations.

Today's Date _____

PATIENT INFORMATION

Patient Name _____Preferred Name _____DOB _____
Address _____ City _____ State _____Zip _____
Male _____ Female _____ SSN _____ Married ___ Single ___ Divorced ___ Child____
Cell/Home phone _____Work_____Preferred#_____
Email for appt. Reminder _____Driver's License#_____
Permission to text and email at the above number and address Yes_____ No _____
Referred By _____
Phone Book Insurance Company Internet Flyer Other

FINANCIALLY RESPONSIBLE PARTY

(If different from patient)

Name _____Married ____ Single ____Divorced _____
Mailing Address _____
Cell/home _____ Work _____Preferred# _____
DOB _____Relationship to Patient _____ Employer_____
SSN _____ Driver's License # _____
Email Address _____

Spouse/Other _____
Mailing Address _____
Cell /home_____ _____Work _____preferred#_____
DOB _____Relationship to Patient _____ Employer_____
SSN _____ Driver's License #_____
Email Address _____

EMERGENCY/ALTERNATE CONTACT INFORMATION

Name of the nearest relative not living with you _____Relationship_____
Address _____Phone _____

DENTAL INSURANCE INFORMATION

Please have your insurance card(s) and photo ID ready for us to make a copy to keep on file

Dental Insurance Company _____Phone _____

Insurance Address _____

Group #_____Subscriber Name _____ Subscriber DOB_____

Subscriber ID #/SSC _____

Employer _____ Employer Address_____

Employer Phone_____ Is this a Medicare Plan ____YES _____NO

Are you Retired _____YES _____NO Is this an individual plan ____YES ____NO

2nd Insurance Company _____Phone _____

Insurance Address _____

Group #_____Subscriber Name _____ Subscriber DOB_____

Subscriber ID #/SSC _____

Employer _____ Employer Address_____

Employer Phone_____ Is this a Medicare Plan ____YES _____NO

Are you Retired _____YES _____NO Is this an individual plan ____YES ____NO

Payment of fees not covered by your insurance plan is due at the time services are rendered. We cannot guarantee payment by your insurance company, and do not have leverage to obtain payment from your insurance company. Dental insurance policies vary widely; therefore you are required to become familiar with your policy exclusions, limitations, deductibles, and required co-payments and/or co-insurance. Dental insurance policies restrict payment for some services, use restricted fee schedules, and excludes some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment. It is your responsibility to keep our office informed of any changes in your insurance coverage, address, or employment, and failing to do so may delay payments made by your insurance company. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance is considered due and collectible from the patient.

I authorize Dr. W. Blake Bybee and/or all associates to release to my insurance company information acquired in the course of my dental care. I authorize benefits to be paid directly to Hidden Springs Dental.

_____ _____

Signature of insured/subscriber, or legal guardian *Date*

Thank you for choosing our practice as your dental health care provider. Our practice is dedicated to quality care and exceptional service. We need your assistance and understanding of our appointment, insurance and financial policies. Thank you for your cooperation in this matter.

PLEASE READ AND INITIAL EACH LINE THEN SIGN AND DATE AT THE END

APPOINTMENTS

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all our patients. In return, we ask that patients make every effort not to change their reserved appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. We require a minimum of **24 hour notice** for any appointment changes so we may accommodate another patient**. If less than 24 hours is given, you will be charged a $40/per hour broken appointment fee.** Appointments are confirmed by mail/phone. If we are unable to reach you, we trust that you will keep your reserved appointment. _____

INSURANCE

If you have dental insurance, as a courtesy to you, we will file your claims with your insurance company. We will try to research and answer any questions you may have about your insurance; however, we must emphasize that as a dental care provider, our relationship is with you-not your insurance company. It is your responsibility to know your insurance policy and be familiar with your coverage. If you have any questions regarding coverage or payment of any claim, that we cannot answer, contact your insurance company immediately. **If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from the patient.** _____

FINANCIAL

Payments are due at the time treatment is rendered. That includes all estimated deductibles and co-payments. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer Care Credit, a dedicated credit card for health services with convenient monthly payments (O.A.C.). You may contact Care Credit at www.carecredit.com or we can help assist you with the application in the office. **If you have a flex/health savings reimbursement program** through your employer, we will be happy to provide you, upon payment in full for your account, with whatever documents are needed for you to obtain direct reimbursement. **Accounts with a balance over 90 days are considered delinquent and may be turned over to a third party collections service**. _____

PAST DUE BALANCES

A past due balance is any amount owing from a prior visit, where insurance is not pending or an insurance payment has not been received by us within 90 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at the time of service**. Any balance older than 90 days is subject to a billing charge of $5.00 per month or finance charges of 18.0% A.P.** _____

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services received. I have read the above information and agree to the above stated policy, and have received a copy of said policy.

_____

Signature of Patient or Responsible Party Date

CONSENT TO PROCEED

• I certify these answers are accurate and correct to my knowledge. Since the change of medical conditions/medications can affect dental treatment, I understand the importance of and agree to notify Dr. Blake Bybee and/or any associate/employee of any changes at any subsequent reservation/appointment.

• I authorize Dr. Blake Bybee and/or any associate/employee as he/she may designate, to perform necessary procedures to maintain my dental health or the dental health of a minor or other individual(s) I am responsible for. These procedures include, but are not limited to, arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

• I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include but are not limited to: Bruising, hematoma, cardiac stimulation, temporary or permanent numbness and muscle soreness. I understand that on rare occasion(s) needles break and surgical retrieval may be required.

• I understand that as part of dental treatment, including preventive procedures such as hygiene cleanings and basic dentistry including restorations of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissue may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek(s) or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

• I understand that as part of dental treatment items including, but not limited to, crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. The unusual situations may require a series of x-rays to be taken by the physician or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

• I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hope of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child(ren). I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

_____ _____ _____

Patient Name/Legal Guardian (Print) ***Signature of Patient/Legal Guardian*** ***Date***

HIPAA

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operation of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and I may contact you at any time to obtain the most current copy of this notice.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name:_____

Signature:_____

Hidden Springs Dental PLLC

Medical History

Patient Name: Birth Date: Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you been told by your physician that you need to premedicate for dental treatment?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

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 Problems	○ 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	○ Yes ○ No	If yes

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:

X Date:_____