NAME:___________________________________

Patient Basic Information

Legal First Name____________________ Nickname____________________

Middle Initial______ Last Name____________________________

Birth Date_______________ Gender ___________

SSN_________________________ Martial Status ______________________

Patient Contact Information

Address_____________________________________ Suite/Apt__________

City ________________________State______________ Zip code__________

EMAIL _______________________________

Home Phone __________________ Cell Phone ________________

Who is responsible for account? ________________________ Relationship: ______________________

Emergency Contact: ___________________ Phone Number: __________________

Relationship: ______________________

Patient Primary Insurance

Subscriber (Insured) Employer ________________________

Subscriber Name ____________________ D.O.B ________________

Social Security # ___________________________________

Insurance Co.__________________________ Phone # _________________________________

ID # _______________________________ Group # ___________________________

Secondary Insurance(if applicable)

Subscriber (Insured) Employer ________________________

Subscriber Name ____________________ D.O.B ________________

Social Security # ___________________________________

Insurance Co.__________________________ Phone # _________________________________

ID # _______________________________ Group # ___________________________

NAME:____

Medical and Dental Information

Your Name: ______________________

Medical Doctor's Name: ____________________ City: __________________

Are you now under the care of a physician? YES NO

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

☐ Anemia	☐ Diabetes	☐ HIV/AIDS	☐ Stroke
☐ Arthritis	☐ Epilepsy	☐ Jaw Pain	☐ Swelling of feet or ankles
☐ Artificial Heart Valves	☐ Fainting	☐ Kidney Disease	☐ Thyroid Problems
☐ Artificial Joints	☐ Glaucoma	☐ Liver Disease	☐ Tobacco Habit/Vape/marijuana use **(please Circle)**
☐ Asthma	☐ Headaches	☐ Mitra Valve Prolapse	☐ Tuberculosis
☐ Back Problems	☐ Heart Murmur	☐ Pace Maker	☐ Ulcer
☐ Blood Disease	☐ Heart Problems	☐ Respiratory Disease	☐ Venereal Disease
☐ Cancer	☐ Hemophilia	☐ Rheumatic Fever	☐
☐ Chemical Dependency	☐ Hepatitis	☐ Shortness of Breath	☐
☐ Circulatory Problems	☐ High Blood Pressure	☐ Sleep Apnea	☐ Other_____________

Have you ever had a reaction to epinephrine? __________________

History of other serious illness, hospitalization or accident? ______________

Do you have additional medical conditions or concerns? _________________

Have you had any changes in your general health lately? ________________

Have you ever taken an antibiotic prior to dental treatment? (If yes, please list type)

____

Medication Reconciliation

Current Medications you are Taking:

____

____

Allergies

Do you have any allergies : YES NO

If yes , please list: ____

NAME:____

Bisphosphonates (Medications used to treat osteoporosis and similar diseases.)

Have you ever taken these medications: YES NO
If yes ,please circle
Alendronate (fosamax) Risedronate (actonel) bandronate (Boniva)

Smoking Status

Do you currently smoke: YES NO

Women

Are you pregnant or suspect you may be: YES NO

Dental History

When was your last dental visit? ________________________________

How frequently do you brush your teeth? ________________________________

How frequently do you floss your teeth? ________________________________

What is the nature of today's visit? ________________________________

Are you nervous about dental treatment? ________________________________

Have you ever had orthodontic treatment? ________________________________

Are you happy with your smile? YES NO

Do you clench or grind your teeth? YES NO

Have you ever been treated for gum disease? YES NO

Do your gums bleed when you brush or Floss? YES NO

Are any of your teeth currently causing you pain? YES NO

Have you ever had any periodontal treatment? YES NO

Are you concerned with loose teeth or teeth loosening? YES NO

Do you have any dental implants, dentures, or partials? YES NO

Have you been told you snore? YES NO
If yes, please comment: ________________________________

Have you been treated for Sleep Apnea? YES NO
If yes, please comment: ________________________________

How Did You Hear About Us?

How did you hear about us? ________________________________

NAME:________________________________

HIPAA Information and Consent

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A notice of Privacy practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices, which include:

- Protected health information may be disclosed or used for treatment in our office or with any specialist office that you may be referred to, payment, and correspondence with insurance companies or health care operations. It may also be used in correspondence with the dental lab, if needed.
- Authorization is required for disclosure of information to family members, care takers or significant others.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

I hereby authorize Drs. Burau High Tech and Cosmetic Family Dentistry (Drs. Burau, P.C.) to release my patient health information as described below:

		Type of Information Allowed to Disclose (Check one or both)		Method of Disclosure (Check one or both)	
Name	Relationship	Medical	Billing	By Phone	In Person

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change out notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

Name________________________________ Date ___________

Drs. Burau Financial Policy

We accept Cash, Check, Visa, MasterCard, Discover , American Express or Care Credit for you convenience. We require that full payment is due at the start of treatment. If payment arrangements are needed, they must be made in advance.

If you would like your treatment to be predetermined, please let us know. A predetermination from your insurance company may take 4 to 6 weeks and is not a guarantee of payment.

We require a minimum of 48 hours notice for appointment cancellations or changes. If you do not come to a confirmed appointment, we reserve the right to charge you $100 per hour for the time lost.

We will be happy to bill your insurance for you. However, your dental insurance is a contract between your employer, you and your dental insurance company. We cannot be responsible for knowing your coverage limitations or yearly benefits. **It is your responsibility to keep track of your benefits used in any other dental offices.**

We do not base your treatment needs on your insurance benefits or limitations. **If your insurance does not pay what we have anticipated or estimated, the difference will be your responsibility and will be billed to you.**

I agree to accept financial responsibility for my treatment. In addition, I authorize my dental benefits to be paid to Drs. Burau, PC. I also authorize Drs. Burau PC to release dental record copies and dental histories pertaining to my treatment when necessary to insurance companies and/or other health care providers.

Signature: ______________________________**Date:**__________

Consent for dental treatment:

I authorize Dr. Burau and/or such associates or assistants as he may designate to perform procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility.

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications, can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointments.

I hereby authorize the doctor to take digital x-rays, study models, photographs or any other diagnostic aids he deems appropriate to make a thorough diagnosis of my dental needs.

I further authorize the release of any information, including diagnosis, digital x-rays and records of any treatments or examinations rendered to my insurance company or consulting professionals.

____

Patient Signature/Legal Guardian *date*

____

Printed name *(if signed on behalf of the patient)* *Relationship*