WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date ______________ Soc. Sec. # ______________ Birthdate ______________

Name ______________ (Last Name, First Name, Initial) Home Phone ______________

Address ______________ Cell Phone ______________

City ______________ State ______ Zip ______ E-mail ______________

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Who should we thank for referring you? ______________

In case of emergency, who should we contact? ______________ Phone ______________

PRIMARY DENTAL INSURANCE

Person Responsible for Account ______________ (Last Name, First Name, Initial)

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________ Home Phone ______________

City ______________ State ______ Zip ______

Responsible Party Employed By ______________ Business Phone ______________

Business Address ______________ Occupation ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

ADDITIONAL INSURANCE

Insured Name ______________ (Last Name, First Name, Initial)

Relationship to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address ______________ Home Phone ______________

City ______________ State ______ Zip ______

Insured Employed By ______________ Business Phone ______________

Insurance Company ______________

Insurance Company Address ______________

Subscriber I.D. # ______________ Group # ______________

Please complete reverse side

DENTAL HISTORY

Former Dentist ______________________ Date of Last X-Rays ______________________

City, State ______________________ How Often Do You Floss? ______________________

Date of Last Dental Visit ______________________ How Often Do You Brush? ______________________

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name ______________________ Date of Last Visit ______________

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: ______________________

____

	Yes	No
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

	Yes	No
Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type ______ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to ______________________ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______________________ Date ______________

NOTICE OF PRIVACY PRACTICES

(DENTAL)

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.

The Health Insurance Portability & Accountabilitv Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

ITEM [illegible] © MAY 2002

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of ____________________, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Barry F Bartusiak D.M.D.

212 Wellness Way, Washington Pa 15301
Phone: 724-225-3680
www.drbarrybartusiak.com

As of April 1, 2011 our financial policy is as stated below:

Thank you for choosing our office for your dental needs. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are available to answer your questions and/or assist you in any way we can.

All payment is due at the time services are rendered (if you have dental insurance this includes your estimated co pay)

We are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental coverage.

The individual insurance relationship constitutes an agreement between the carrier and the patient- not this dental office.

As such, we can make no guarantee of estimated coverage or payment from your insurance company. However, please know that we will do everything possible to see that you receive the full available benefits of your policy.

Payment Options

All patient co pays and/or fees for services are due prior to, or on the date that services are rendered. ***There are no exceptions to this policy.*** If the estimate our office has provided you is less than the balance owed, please understand that the additional balance is due and is to be paid in full within 30 days of your billing statement.

1. Services that are paid in full 48 hours prior to the scheduled appointment are eligible for a courtesy discount of 5%. This may be paid by cash, check, debit or credit card.
2. We can help you apply for a payment plan thru Care Credit or Springstone Patient Financing. If approved you would be eligible for extended payments options.
3. For payment being made to a billing statement there is no 5% courtesy discount given.

- Please note that Co-Pay amounts quoted by our staff are only and estimate based on the information that you provide to us regarding your insurance coverage
- Please remember – You (the patient) is responsible for any portion of your dental bill that is un-paid, denied, or pending (for more than 60 days) with your insurance company within 30 days of receiving your statement.
- Please remember that if you apply for an extended payment plan through a finance company, though our office can help you with the application process, you are subject to the terms and conditions set forth by the approving financial institution. Our office takes NO responsibility for changes in your payment agreement, changes in your due date, or any additional charges that may or may not be imposed on your credit account, and has no authority or responsibility to investigate any of the above on your behalf.

Patients Name (Print)   Patient/ Guardians Signature   Date

Barry F Bartusiak D.M.D.
Consent for Dental Treatment

________________________________ _______________________

Patients Name Date

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE DOCTOR BEFORE INITIALING.

________ **1. TREATMENT:**
I understand that I may need to have the following dental treatment performed:
Fillings, Crowns, Bridges, Dentures, Extractions, Impacted Teeth removal, Root Canals, Mini Implants, Orthodontics, Treatment of Periodontal Disease or other work deemed necessary.

________ **2. DRUGS AND MEDICATIONS:**
I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

________ **3. RISKS OF DENTAL ANESTHESIA:**
I understand that pain, bruising and occasional temporary or sometimes permanent numbness in lips, cheeks, tongue, or associated facial Structure can occur with "shots". About 90% of these cases resolve themselves in less than 8 weeks. Although very rarely needed, a referral To a specialist for evaluation and possible treatment may be needed if the symptoms do not resolve.

________ **4. FILLINGS:**
I understand that a more extensive restoration than originally planned, or possible root canal therapy, may be required due to additional Conditions discovered during preparation. I understand that significant changes in response to temperature may occur after tooth Restorations I realize that fillings are rarely "permanent" and usually require periodic replacement with additional fillings and/or crowns.

________ **5. CROWNS, BRIDGES, INLAYS AND ONLAYS:**
I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are probe to loosening and may need re cementing. I will notify my doctor of that occurrence so That a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, Size, etc. of a crown must be made prior to the final fabrication. It is my responsibility to return within one month of tooth preparation for final cementation of restoration. I understand I may need further treatment in this office or possibly by a specialist if complications arise during treatment, and any costs this incurred are my responsibility.

________ **6. DENTURES:**
I understand that wearing dentures is not a simple process, that chewing efficiency will be diminished and that dentures are not "permanent". I also understand that, while I will no longer suffer from dental decay or infection, I could experience denture related Problems such as; shrinking bone and gums, poor chewing ability, altered speech, reduced taste and constant denture movement. Most Denture wearers become used to these symptoms quickly whole others take time and there are a small number of patients who never Do. Immediate dentures (placement of a denture immediately after extractions) may be quite uncomfortable for several days. Immediate Denture (also known as a temporary) requires frequent adjustments and one or more relines within several months. I understand that Failure to keep appointments may result in a less than desirable outcome. After all adjustments are made and I am completely satisfied Then a final set of dentures will be made. If a remake is required due to my delay, additional fees may be incurred.

________ **7. EXTRACTIONS:**
Alternatives to tooth removal include root canal therapy, extensive restorations, periodontal (gum) treatment or crowns. I understand that Removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of Removing teeth include, but are not limited to; pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw, and loss of feeling in my lip or other facial areas, cheek, tongue, gums, and teeth. Such numbness may be temporary or permanent. Also, there is the possibility of a small root piece being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a oral surgeon may be necessary at some point.

________ **8. PERIODONTAL:**
Periodontal disease can be a serious condition, causing gum and bone inflammation and/or loss and may lead to loss of permanent

teeth, heart disease and risk of stroke. Possible treatment plans have been explained to me, including deep cleaning, gum surgery and bone grafting, extraction of teeth and tooth replacement. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctors instructions, including strict observance of recall appointments. I understand that care by a specialist may be necessary.

________ **9. ROOT CANAL THERAPY:**

I realize root canal therapy has a very high success rate; however, there is no guarantee root canal treatment will save a tooth, and Complications can occur. During the procedure some complications or conditions might be noticed which would require a referral to a specialist or extraction. These include; extensive decay making the tooth not restorable, perforations, a fractured tooth, curved or hardened canals, and extra canals whose presence couldn't be diagnosed earlier leading to persistent pain and infection. I understand that root canal files are extremely fragile instruments and may sometimes separate within the root, which may or may not affect success. teeth exhibiting extensive infection where conventional root canal therapy is not enough might need further surgery or treatment by a specialist at additional costs to me. A small percentage of root canals fail despite the best efforts. I understand that specialty care may be indicated if complications arise and any costs incurred are my responsibility. After root canal therapy, a crown is usually needed, if not placed right away, it might lead to fracture of the tooth and possible extraction.

________ **10. IMPLANTS:**

I understand the purpose of dental implant procedures is to provide support to an existing denture, partial denture, or to restore and area that is missing a tooth. This process may take steps until I have the finished product. In the event that the implants fail, they will be removed through a subsequent surgical procedure. I understand that one or more of the implants may fracture during insertion or during the implants life cycle. If a fracture occurs, I give consent to leave the implant in my jaw or remove it under professional conditions and using a professional judgment. I further understand that swelling, infection, bleeding and or jaw pain may be associated with this or any surgical procedure and that said conditions may occur in my tongue, lips, chin, gum or jaw as a result of this procedure.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I have had the opportunity to have all my questions answered by my doctor, and I certify that I understand English. My signature below signifies that I understand the treatment and anesthesia that is proposed for me, together with the known risks and complications associated with that treatment. I hereby give my consent for the treatment I have chosen.

______________________________ ______________

Patient or Guardians Signature Date

______________________________ ______________

Doctors Signature Date

______________________________ ______________

Witness's Signature Date