BULLARD
DENTAL

Patient Information

First Name: _____ Preferred name: _____

Last Name: _____ MI: _____ Title: _____

Gender: _____ Birthdate _____ SS Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone number: _____

Mobile phone number: _____

Email: _____

Emergency Contact (name and phone number)

_____

How did you find us? _____

Preferred contact method? Home phone, Mobile phone, Mobile text, Email, Do not contact

_____

Responsible Party (if other than patient):

First Name: _____ Preferred name: _____

Last Name: _____ MI: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Medical History

Pharmacy name: _____ Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Check any condition that apply to you:

- ☐ None
- ☐ Alcoholism
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint/Pins
  - Type: _____
  - Age: _____
- ☐ Aspirin Therapy
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
  - Type: _____
- ☐ Chemotherapy
- ☐ Coumadin Therapy
- ☐ Dementia
- ☐ Diabetes
  - Type: _____
- ☐ Dialysis
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Hearing Impairment
- ☐ Heart Murmur
- ☐ Heart Surgery
  - Date: _____
- ☐ Heart Trouble
  - Type: _____
- ☐ Hepatitis
  - Type: _____
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease/COPD
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mobility Impairment
- ☐ NON-DENTAL Implants
  - Type: _____
- ☐ Organ Transplants
  - Type: _____
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis(TB)
- ☐ Ulcers
- ☐ Visual Impairment
- ☐ Other Disease/Illness
  - Type: _____

Please list all medications: _____

_____

_____

_____

Please list all allergies: _____

_____

Are you taking or have you ever taken medications for osteoporosis? _____

Have you been admitted to a hospital in the last 2 years: _____

Do you have a regular physician? (Name and phone number)

_____

Do you use tobacco products? _____

Do you use controlled substances? _____

Dental History

How long has it been since your last visit to the dentist? _____

Reason for the visit? _____

_____

Have you had any complications following dental treatment? _____

_____

Are your teeth sensitive to hot or cold? _____

Do your gums bleed when you brush or floss? _____

Do you grind your teeth? _____

Have you ever been treated for Periodontal Disease? _____

Do you like your smile? _____

Dental Insurance

Primary Dental Insurance

Responsible Party First Name: _____

Responsible Party Last Name: _____

Responsible Party Birthdate: _____

Responsible Party Social Security Number: _____

Responsible Party Address: _____

_____

Employer _____

Insurance Company _____

Insurance Company Phone Number _____

Subscriber ID/Social Security Number _____

Group ID _____

Secondary Dental Insurance

Responsible Party First Name: _____

Responsible Party Last Name: _____

Responsible Party Birthdate: _____

Responsible Party Social Security Number: _____

Responsible Party Address: _____

_____

Employer _____

Insurance Company _____

Insurance Company Phone Number _____

Subscriber ID/Social Security Number _____

Group ID _____

HIPAA Acknowledgement Form

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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available in the office in print form or on the website).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Jonathan L. Bullard, DMD, PC has the right to change his Notice of Privacy Practices from time to time and that I may contact Jonathan L. Bullard, DMD, PC at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Jonathan L. Bullard, DMD, PC restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Jonathan L. Bullard, DMD, PC is not required to agree to my requested restrictions, but if Jonathan L. Bullard, DMD, PC does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Jonathan L. Bullard, DMD, PC has taken action relying on this consent.

By signing this form, I acknowledge that I received and read this organization's Notice of Privacy Practices.

Please Sign: _____

Date: _____

PATIENT RESPONSIBILITY AGREEMENT and INSURANCE POLICY

We would like to take this opportunity to welcome you to our practice and assure you that we will do our utmost to provide you with the best possible care. Payment for services are due the day they are performed. Cash, check and credit cards are all accepted forms of payment. Diagnostics, like x-rays, and treatment are rendered based on standards of care adopted by the doctor. These may conflict with insurance frequencies for coverage or patient's requested treatment desires. Ultimately, after discussion, treatment may be required to continue care.

PATIENTS WITH INSURANCE COVERAGE

We will be glad to help you obtain the appropriate benefit from your dental insurance carrier and we will bill your carrier as a courtesy to you. However, you are responsible for resolving any problems with your insurer and are ultimately responsible for full payment of the account. We will be happy to request a pre-treatment estimate of benefits from your insurance carrier prior to completing any dental treatment if you request us to do so. Routine treatment is generally performed without submitting a request for a pre-treatment estimate of benefits. We

would like to highlight a misconception that dental insurance was designed to pay 100% of dental care. That is not true. Dental insurance is a benefit to help offset the cost of dental care and seldom pays 100%. Most contracts have annual limits and/or various degrees of copayment. Insurance companies determine their fees based on the premium that you or your employer pays for your policy. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality of dental care. The treatment recommended by our office is never based on what your insurance company will pay. Your treatment will never be governed by your insurance policy; it will be based on your needs. Your personal estimate percentage will be due the date services are rendered, and for your convenience our office does accept major credit cards. Should you elect to assign your benefits directly to our office, we allow 90 days from the date of service for the receipt of payment from your insurance company. If there should be a delay in the insurance companies processing, the entire balance is due at that time. Please remember that ultimately you are responsible for all services rendered. Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required from you as per your insurance agreement. Even if you have double coverage (if you and your spouse both have insurance), there may still be a portion that will be your financial responsibility.

ADDITIONAL TERMS

When possible, we require a 24hr notice before canceling your appointment. By giving 24 hours' notice, this will allow other patients an opportunity to schedule and prevent us from scheduling your canceled appointment too far in the future.

Checks returned by your bank are subject to a $35.00 processing charge.

BY SIGNING HERE I ACKNOWLEDGE THAT I HAVE READ THE ABOVE AND UNDERSTAND THE POLICIES OF THE OFFICE:

Please Sign: _____

Date: _____