Office Policies and Procedures

Insurance Responsibility

It is your responsibility to make sure that the dentists at Byerly Family Dentistry are part of your insurance plan. Please reference the telephone number on the back of your insurance card to verify this information. We are "participating providers" in a large number of plans; however, we are not contracted in all plans.

It is your responsibility to understand your plan benefits. Our doctors will place white composite restorations unless otherwise requested. Many insurance plans cover fillings at the amalgam (metal) rate. You; the patient, are liable for the difference in cost. As a courtesy, we are happy to file insurance claims for your dental procedures as long as you provide us with the necessary information. Please contact your insurance company directly with any questions you have about your coverage. We are happy to get an estimate from your insurance if requested prior to treatment. Please allow 2-4 wees for processing.

Appointment Confirmations

If you are unable to keep your appointment, you must notify our office at least 24 hours in advance to cancel and/or reschedule so we can have sufficient time to call those who are on the waiting list. Repetitive no shows and cancellations will be subject to a charge. After two broken appointments in which you do not provide a 24 notice, we reserve the right to remove you from our list of active patients and dismiss you from the practice.

Consent for Services

I consent to the diagnostic procedures and treatment by the dentist for proper dental care. I understand that my dental insurance carrier may pay less than the total bill for services. I agree to be responsible for payment of all services rendered regardless of what insurance may cover. I agree to be responsible for any balance due, including charges or service fees, from debt collection actions. Financial arrangements must be made in advance of treatment if you are unable to pay in full at the time treatment is rendered.

Payment plans

If you have insurance, we will file your claim. A deposit we be requested for all major services. Once insurance pays, we will send you a bill for the balance. If you are unable to pay the balance in full payment arrangements can be established.

Thank you for choosing us to partner with you in caring for your dental health.

Signature ______________________________ Date ______________

PATIENT REGISTRATION
AND
MEDICAL/DENTAL HISTORY

Medical Alert

Pharmacy Name ___ Phone ___

So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.
(PLEASE PRINT)

Date ___

Home Phone ___ Work Phone ___ Cell/Pager ___ Email ___

Patient Name ___

Address ___

City ___ State ___ Zip ___ Social Security # ___ Driver's Lic.# ___

Sex: Male Female Age ___ Birthday __/__/__ Single Married Widowed Separated Divorced

Employed By ___

Occupation ___

Business Address ___

City ___ State ___ Zip ___ Tel. ___

Spouse Name ___ Birthday __/__/__

Employed By ___

Business Address ___

City ___ State ___ Zip ___ Tel. ___

Social Security # ___

Person Responsible For Account

Name: ___ Relation: ___

Billing Address: ___

Hm# ( ) ___ DL# ___

Employer: ___

Wk# ( ) ___ Ext: ___ SS# ___

Dental Insurance Primary Carrier

Insured's Name ___ Social Security # ___

Insurance Company ___ Telephone ___

Address ___

City ___ State ___ Zip ___

Group Number ___ ID Number ___ Birthdate ___

Insured's Employer ___

Dental Insurance Secondary Carrier

Insured's Name ___ Social Security # ___

Insurance Company ___ Telephone ___

Address ___

City ___ State ___ Zip ___

Group Number ___ ID Number ___ Birthdate ___

Insured's Employer ___

In case of emergency, who should be notified? ___ Tel. ___

Whom may we thank for referring you? ___

Medical History

Physician's Name ___ Date of Last Physical ___

Address ___ Tel. ___

Please check the box of any condition you may have had

- ☐ A.I.D.S./ HIV Positive or Other
- ☐ Allergies to Anesthetics
- ☐ Allergy to Colored Dyes
- ☐ Allergy to Latex
- ☐ Angina Pectoris
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Aspirin Taken Daily
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer, Leukemia
- ☐ Chemical Dependency
- ☐ Chemotherapy/Radiation Therapy
- ☐ Chronic Diarrhea
- ☐ Circulatory Problems
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ General Allergies* (List Below)
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease or Attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problem
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Premedicate
- ☐ Psychiatric Care
- ☐ Recent Weight Loss
- ☐ Respiratory Problem
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Neck Glands
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other* (List below)

*General Allergies: ___

*Other: ___

Patient Name

DENTAL HISTORY

What is the reason for your visit today?____________________

Is there anything about having dental treatment that you would like us to know? ❑ Yes ❑ No

If yes, please describe____________________

Date of Last: **Dental Visit**______ **Dental Cleaning**______ **Full Mouth X-ray**______ **Bitewing X-rays**______

What treatment was done at your last dental visit?____________________

Previous Dentist's Name____________ Telephone____________

Address ____________________

City ____________ State____________ Zip Code____________

How often do you have dental examinations?____________ How often do you floss?____________

What other dental aids do you use? (Interplak, toothpick, etc.)____________

Do you have any dental problems now? ❑ Yes ❑ No If yes, please describe:____________

Circle "Yes" or "No" to each item.

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? Yes No (pencils, pipe, pins, nails, fingernails)
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Smoke/chew tobacco? Yes No
- How much?____________

Have you ever had:

- Orthodontic treatment? Yes No
- Oral surgery? Yes No
- Periodontal treatment? Yes No
- Your teeth ground or the bite adjusted? Yes No
- A bite plate or mouth guard? Yes No
- A serious injury to the mouth or head? Yes No
- If yes, please describe, including cause.____________

Are any of your teeth sensitive to:

- Hot or cold Yes No
- Sweet Yes No
- Biting or chewing Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or a change in your bite? Yes No

Do you have difficulty in chewing on either side of the mouth? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where?____________

Have you ever experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in opening or closing the mouth? Yes No
- Headaches, neckaches or shoulder aches? Yes No
- Sore muscles (necks, shoulders)? Yes No

Are you happy with your smile? Yes No

Are you pleased with the color of your teeth? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If yes, what is your biggest concern?____________

Have you ever had an upsetting dental experience? Yes No

If yes, please describe____________

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, list____________

Have you ever responded adversely to medical or dental treatment? ❑ Yes ❑ No

Have you ever been advised to be pre-medicated prior to any dental treatment? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No If yes, what____________

Have you ever taken Phen-Fen? Or Redux? ❑ Yes ❑ No If so, have you seen a cardiologist for a consult since taking it? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No If yes, for what condition____________

If Patient is a child what is his/her weight? ____________

Have you had a recent transfusion? ❑ Yes ❑ No

Is there anything else we should know about your medical history____________

Women — Are you: Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

____________ Staff /Dr.'s Initials ______ Date

AUTHORIZATION AND RELEASE

The above information is accurate and complete to the best of my knowledge and is only for use in treatment, billing and processing of insurance for benefits for which I am entitled. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care, to third party payers and/or other health practitioners.

I authorize my insurance company to pay directly to the dental office the benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

____________ Signature of Patient or Parent of Minor ______ Date

Byerly Family Dentistry

Lee E. Byerly DDS * Ryan C. Byerly DDS

Notice of Privacy Practices

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.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

• To other health care providers (i.e., your general dentist, oral surgeon. etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.)

• To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, electronic filing of insurance)

• To certifying, licensing and accrediting bodies (i.e., state dental boards, etc.) in connection with obtaining certification, licensure or accreditation

• Internally, to all staff members who have any role in your treatment

• To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling. etc.

• To your family and close friends involved in your treatment

• 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 or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

• Request restrictions on the use and disclosure of your protected health information

• Request confidential communication of your protected health information

• Inspect and obtain copies of your protected health information through asking us

• Amend or modify your protected health Information in certain circumstances

• Receive an accounting of certain disclosures made by us of your protected health information

• You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation). We have the following duties under the privacy rules:

• By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information

• To abide by the terms of our Privacy Notice that is currently in effect

• To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us and that, if we do so, we will provide you with a copy of the revised Privacy Notice. Please note that we are not obligated to:

• Honor any request by you to restrict the use of disclosure of your protected health information

• Amend your protected health information to see, for example, if it is accurate and complete

• Provide an atmosphere that is totally free of the possibility that our protected health information may be incidentally overheard by other patients and third parties. This Privacy Notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________ have received a copy of Dr Byerly's notice of privacy practices.

Signature ____ Date ____________.