Chart #: ____________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ______________________________________ Date: ____________
Title Last First MI (Preferred Name)
Gender: __________ Family Status: __________

Birth Date: ________ Driver's License No. ____________ Social Security #: ____________

Phone (Home): ____________ (Work): ____________ Ext: ______ Email: ____________

Fax: ____________ Pager: ____________ Other: ____________

Address: ______________________________________
Street Apartment #

____
City State Zip Code

Health Information

Reason for this visit: ______________________________________

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies __________ __________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral-Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due date: ________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Taken Phen-fen
- ☐ Taken Redux

OTHER:
- ☐ ____________
- ☐ ____________

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Name of Physician: ______________________________ Phone: ____________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________________
- Please list any medication that you are currently taking: ______________________________________

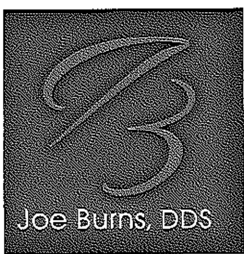
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________________ Date: ____________
Signature of patient, parent or guardian

Referral Information

Name of person or office referring you to our practice: ______________________________________



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Ph. 601.956.5410 • Fx. 601.956.5708
www.joeburnsdds.com

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other __________

Insurance Plan Name and Address: ______________________________

____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination

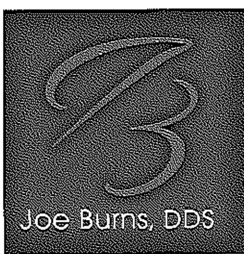
In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

______________________________ Date: __________ Relationship to Patient: Self

Signature of patient, parent or guardian



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Office Policy

Prior to being examined by the Doctor, each patient must have a completed Medical History Form. In addition, a single Office Policy and Insurance Policy form will need to be completed for each family.

No Show Policy: We expect our patients to be present at all scheduled appointments exclusively reserved for them. To avoid a $50.00 missed appointment/late notice fee, a 48-hour notice is required. Fee must be paid before being scheduled again.

Missed Appointments: Frequently missed appointments without a 48-hour notification may result in dismissal from our practice.

Late Arrivals: Late arrival for scheduled appointments leads to inadequate time to accommodate the remaining patients on the schedule. Late arrivals of greater than 10 minutes risk not being seen. We will try to accommodate late appointments as time permits, however, those patients who are here at their requested time will be seen first.

Financial Policy: For those patients without dental insurance benefits, full payment is due at the time of service. As a special service to you, should you require major restorative work, a 5% discount will be offered to you if you pay by cash or check for your entire treatment plan in full.

We accept cash, checks, debit cards and credit cards (Visa, MasterCard, Amex and Discover). In addition we offer Care Credit and Citi Health Card healthcare financing that allow for monthly payments- **Please ask for details.**

We do not accept post-dated checks and checks returned with insufficient funds will be charged $30.00. After **90 days** we will assign all unpaid accounts to our attorney for collection. You will be responsible for all costs of collection.

Patients that fail to comply with the above policies may be subject to dismissal from our practice.

Thank you for reading our Office Policy. Please let us know if your have any questions or concerns. We appreciate the trust and confidence you have placed in us for your dental care.

I have read, understand and agree to abide to by the Office Policy of Joe Burns, D.D.S. and further acknowledge that failure to comply may result in dismissal from the practice:

____ ____/____/____

(signature of responsible party) (date)

Dental Insurance Policy

- As a courtesy to our patients, we do file your insurance for you. However, it must be stressed that your insurance is a contract between **YOU, YOUR EMPLOYER and THE INSURANCE COMPANY.** We are not a party to this contract unless you are a member of a PPO group in which the doctor participates. In such cases, we will handle your claims according to our agreement with the insurance company, if one exists.

- While we will do our best to help you receive your maximum benefits, we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc.

- Not all services are covered by your plan and every plan is different. If you have questions about your benefits, please call your insurance company. It would be helpful for you to know your enrollment or effective date, annual deductible and annual maximum.

- **You are expected to pay your deductible and the estimated portion of your fee at the time services are rendered. However, this is only an estimate-** if there is any difference after your insurance pays, we will send you a statement.

- You are responsible for the timely payment of your account. If your insurance company has not paid your claim in full within 60 days, the balance and all follow-up with the insurance company becomes your responsibility. As a reminder, **after 90 days we assign all accounts over to our attorney for collection.**

I hereby authorize payment of dental benefits otherwise payable to me to be paid directly to Joe Burns, D.D.S. Furthermore, I realize that I am ultimately responsible for payment.

________________________________ ____/_____/_____

(signature of responsible party) (date)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name:
Address:
Telephone: E-mail:
Social Security #:

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, ________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ____________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: ____________________________

Relationship to Patient: ______________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________________ Date: ______________

Acknowledgement of Receipt
Notice of Privacy Practices
Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.
HIPAA web-site: http://www.hhs.gov/ocr/hipaa/finalreg.html

You May Refuse to Sign This Acknowledgement*

I, ________________, have received acknowledgement of this office's Notice of Privacy Practices.

______________________________________ __________

Signature Date:

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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