Patient Registration

Dr Ashley E. Burns, DDS
5012 Portico Way
Midland, Texas 79707

Patient Information:

First Name: _____ Last Name: _____ Preferred Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc Sec #: _____ Age: _____

E-mail Address _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other

Emergency Contact Name: _____

Relationship to Patient: _____

Emergency Phone #: _____

Referred to us by: _____

Physician's Name & Phone #: _____

Preferred Pharmacy:

Name: _____ Location (intersection): _____

Responsible Party: (if different than patient)

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other _____

First Name: _____ Last Name: _____

Address (if different from above): _____

City, State, Zip: _____

Home Phone: _____ Cell: _____

Dental Insurance Information:

Insurance Company Name: _____ Ins. Phone Number: _____

Ins. Company Address: _____

City, State, Zip: _____

Employer: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____

Policy Holder Soc. Sec. # or Member ID: _____

Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

Have you ever used or are currently using topical fluoride? Yes No

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

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

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	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 change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where _____

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? (pencils, pipe, etc.)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use other tobacco products?	Yes	No

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

Please describe, including cause _____

Have you 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
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to replace your silver fillings?	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
Have you ever had an upsetting dental experience?	Yes	No
Have you ever been told to take a pre-medication prior to dental treatment?	Yes	No
Is there anything else about having dental treatment that you would like us to know?	Yes	No

Please describe _____

Please describe _____

If yes, please describe _____

_____

(Please complete other side)

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ..... Yes No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
   If yes, please list name and dosage _____
3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes No
   If yes, please list name and dosage _____
4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes No
   If yes, please list name and dosage _____
5. Are you aware of having an allergic **(or adverse)** reaction to any substance or medication? ..... Yes No
   If yes, please specify _____
6. Have you been a patient in the hospital during the past five years? ..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)...	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle) ...	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S./H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Yellow Jaundice ..	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care..	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Cancer	Yes	No

8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women:** Are you pregnant or think you could be pregnant? Yes _____Months No **Nursing?** Yes No
11. Do you use birth control prescriptions? ..... Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Insurance Disclaimer

(Please Read Carefully)

Please note we do not accept nor participate with any DMO/HMO Insurance plans, prepay plans, Medicare, Medicaid or discount plans.

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

The only fees that are guaranteed when a treatment plan is proposed to you is our standard fee schedule. A pre-treatment estimate can be submitted on your behalf but again is not a guarantee of payment. If you would like this done, you must specify to the front office staff before any work is initiated. **(This can take a minimum of 3 weeks but is determined by your insurance company) _____ (initial)**

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of your coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, it will remain on your account as a credit that can be applied to your future appointments. Also, remember dental insurance plans are not designated to cover all your dental needs.

I, _____, have chosen to allow **Ashley Burns DDS** to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have and to update the front office staff of any changes that my employer of myself has made to my dental insurance. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only and **estimate of benefits**.

Print Name:_____ Date:_____

Patient Signature: _____

Staff Signature:_____

Appointment and Cancellation Policies

We ask our patients to give us 48 hours whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Policy and Fees:

Cancellation or rescheduling of an appointment with 48 hours or more notification - NO CHARGE.

Failure to give 24 hour advance notice or No show:

- $100 for a hygiene appointment
- $150 for a treatment appointment

Late Policy

If you are running late for your appointment please contact our office. If you arrive more than 15 minutes late to your scheduled appointment time you will need to be rescheduled and a cancellation fee of $50 will be applied to your account.

If you have (2) or more NO SHOWS in a 12 month period, you will be required to make a deposit to HOLD an appointment time or you may be discharged from our practice.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask.

I have read and understand the above mentioned policy.

_____ _____

Patient signature (Parent or Guardian if minor) Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child (ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please Call [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ___/___/___

Dr. Ashley Burns DDS' office is going paper-less, therefore we will no longer be billing patients or sending out statements unless requested.

Credit Card Authorization Form

July 1, 2020

Responsible Party:

Effective January 1, 2014, I authorize Dr. Ashley E. Burns to keep my signature on file and charge my:

___VISA ___MASTERCARD ___AMERICAN EXPRESS ___DISCOVER ___CARECREDIT

___ I understand that after my insurance has closed the claim and paid, I have 45 days to take care of the remaining balance

___ I also understand that a financial coordinator will administer a courtesy phone call before my card is charged. It is my responsibility to make sure the financial coordinator can contact me during business hours

___I assign my insurance benefits to Dr. Ashley E. Burns

___ I understand that this form is valid until my card expires and that Dr. Ashley E Burns files my dental insurance as a courtesy. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I am aware that my card information may be verified at each visit to ensure validation.

Patients Name:_____

Cardholders Name:_____

Credit Card Number:_____

Expiration Date:_____ CVV Code (For CareCredit Only):_____

Cardholders Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Ashley E. Burns, D.D.S.
4214 Andrews Hwy.
Suite 300
Midland, Texas 79703
Phone (432)697-3333 Fax (432)697-0240

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information has been provided to me in the Notice of Privacy Practices. I understand 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 (insurance companies).

Conduct normal healthcare operation and quality assessments.

Conduct appointment reminding activities such as voicemail or answering machine messages, messages left with secretaries or family members, postcards or letters.

Discuss treatment with a parent, spouse, family member, or any one responsible for paying my account.

I have received and understand 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 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 information is used or disclosed to carry out treatment, payment or health care operations.

I understand that I do not have to sign this Acknowledgement.

Print Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment. _____
I could not communicate with the patient. _____
The patient refused to sign. _____
The patient was unable to sign. _____

Other (please describe). _____

_____ _____

Staff Signature Date