MARIYA BARNETT, DDS
Family & Cosmetic Dentistry

Welcome to our office!

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____ Preferred name _____ M/F
Age _____ Birth date_____ Social Securty: _____
Name of parent or guardian (if patient is a minor) _____
Mailing address _____ City _____State _____ Zip _____
Home phone _____ Cell phone _____Email: _____
Employer _____ Work phone _____
Spouse's name _____ Spouse's employer _____ ❑ Unmarried
Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION: ❑ Not covered by dental insurance
Primary Dental Insurance Co._____ Phone _____
Subscriber name _____ Date of birth _____ Social security _____
Identification/Subscirber number _____ Group number _____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Phone _____
Date of birth _____ Social Security number _____ Group number _____

Emergency contact name/phone, other than spouse _____

MEDICAL HEALTH HISTORY

❑ Do you have or have you had any of the following?
(Please check any that apply)
❑ Cancer or tumor
❑ Heart ailment or angina
❑ Heart murmur, mitral valve prolapse, heart defect
❑ Rheumatic fever or rheumatic heart disease
❑ Artificial joint or valve
❑ High or low blood pressure
❑ Pacemaker
❑ Tuberculosis or other lung problems
❑ Kidney disease
❑ Hepatitis or other liver disease
❑ Alcoholism
❑ Blood transfusion
❑ Diabetes
❑ Neurologic condition
❑ Epilepsy, seizures, or fainting spells
❑ Emotional condition
❑ Arthritis
❑ Herpes or cold sores
❑ AIDS or HIV positive
❑ Migraine headaches or frequent headaches
❑ Anemia or blood disorders
❑ Abnormal bleeding after extractions, surgery, or trauma
❑ Hayfever or sinus trouble
❑ Allergies or hives
❑ Asthma
❑ Hyper/Hypo Thyroid
❑ Stroke

Other condition not listed above? _____

Are you allergic to, or have you reacted adversely to any medication?

_____

Are you taking any of the following?
❑ Aspirin
❑ Anticoagulants (blood thinners)
❑ High blood pressure medicine
❑ Antidepressants or tranquilizers
❑ Insulin, Orinase, or other diabetes drug
❑ Cortisone or other steroids
❑ Osteoporosis (bone density) medicine
❑ hormones or contraceptives
❑ Other:_____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Women:
❑ Pregnant or may be pregnant?
Expected delivery date: _____
❑ Nursing

Dental Health History

Reason for today's visit? _____
How do you rate your overall dental health on a scale of 1-10 (1- Poor, 10- Excellent)? _____
How important to you is your dental health on a scale of 1-10 (1- Not important, 10-Extremely)? _____
How many times a day do you brush your teeth? _____ Date of your last professional cleaning _____
Have you ever been told you have periodontal disease (gum disease)? □Yes □No
How many times a day do you floss your teeth? _____

Please answer the following questions to the best of your ability

	Yes	No		Yes	No
Are you apprehensive about dental treatment	□	□	Do you clench or grind your jaws frequently?	□	□
Have you had problems with previous dental treatment?	□	□	Does it hurt when you chew or open wide to take a bite?	□	□
Are your teeth sensitive?	□	□	Do you have any jaw symptoms or headaches upon awakening in the morning?	□	□
Do your gums bleed easily?	□	□	Do you have difficulty in chewing your food?	□	□
Do you wear dentures?	□	□	Are you aware of an uncomfortable bite?	□	□
Do you gag easily?	□	□	Do you avoid brushing any part of your mouth because of pain?	□	□
Does food catch between your teeth?	□	□			
Have you ever noticed slow-healing sores in or about your mouth?	□	□			
Do you or have you been told you snore?	□	□			

Please add anything else you would like for us to know about you!

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient (parent if minor) _____ Date _____

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Office Policies

- Financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment, including any insurance benefits. Payment is due at the time of service. We accept Visa, Master Card, Discover, American Express, Personal Checks or Cash. Payment arrangements can also be made through Care Credit. Any dental services performed without previous financial agreements, must be paid at the time services are rendered. If you have any questions concerning this payment method, please speak with Amanda our payment expert.

- If you are unable to make your dental appointment, we ask you call our office at least 24 hours prior to your dental appointment to make other time arrangements or reschedule. A $50 charge will be added to your account if notice is not received timely. If consistent cancellations without prior notice occur you may be asked to pay for your visit in advance to reserve your appointment again.

  We understand how important and busy schedules can get and want to be respectful of your time; therefore we ask that you arrive promptly in order for us to provide the same timely courtesy to other patients as well. By signing below, I acknowledge that I am aware and agree to follow the office policy.

Signature _____ Date _____

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Your Dental Insurance

We will help prepare the patient's insurance forms, assist in making collections from insurance companies and will credit any collections to the patient's accounts. The "Patient Portion" on our treatment plan is only an estimate of what your insurance may pay. However Dr. Mariya Barnett does not render services on the assumption that our charges will be paid in full by insurance companies. In the event your insurance company pays less than their estimated amount, *you are responsible for the unpaid portion and will be billed.*

- *Although insurance is your responsibility… we can help. Regardless of what we might calculate as your benefit in dollars, we must stress the fact that you are responsible for the total cost of your dental care. As a courtesy to you, we will file your insurance to get the maximum amount due you under your plan's provision. You should contact your employer or union to obtain precise information regarding your benefits.*

- *Many plans tell their insured that they will be covered "up to 80%" or up to "100%," but do not clearly specify limitations. We have found that most plans covered about 35% or 65% of major services based on the plan's pre-established maximum fee allowances and caries from carrier to carrier.*

- *You may receive a letter from your insurance company stating that dentals fees are higher than usual and customary, rather than saying their benefits are low. An insurance company surveys a geographic are, finds the average fee and then takes 90% of that fee and considers it customary.*

- *Many routine dental services are not covered by insurance carriers.*

In the interest of your good health and the aesthetics of your dental work, Dr. Mariya Barnett prefers to use composite (tooth colored) fillings and porcelain faced (tooth colored) crowns on all teeth, unless alternate treatment is needed. You are being informed that most, but not all, insurance companies only allow the benefit of amalgam and metal crowns on posterior (back) teeth. *You will be responsible for the amount that your insurance does not cover.*

I have read the above conditions of treatment and payment and agree.

Signature (parent if minor) _____

Date _____

Relationship to patient _____

MARIYA BARNETT, DDS
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Authorization and Consent

To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Mariya Barnett DDS, PLLC to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Mariya Barnett DDS, PLLC health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Mariya Barnett DDS, PLLC may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Mariya Barnett DDS, PLLC does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Mariya Barnett DDS, PLLC already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature (parent signature if minor): _____ Date: _____

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Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. My signature below is acknowledgement that I have reviewed the Notice of Privacy Practices for the office of Dr. Mariya Barnett, DDS PLLC and am in agreement.

Patient name _____ Date _____

Signature (parent if minor) _____ Date _____

Witness _____ Date _____

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:

_____

_____

□ Information is not to be released to anyone.

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

Messages

The following numbers may be used to contact me

□ my home _____
□ my work _____
□ my cell _____
□ other _____

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: ____/____/_____