Walnut Ranch DENTAL SPA

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Date _____

PATIENT INFORMATION *(CONFIDENTIAL)* Patient's Sex ☐ F ☐ M

Name _____ Birth date _____

Address _____ City_____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Do you prefer to receive calls at your: ☐ Home ☐ Cell ☐ Work

SSN _____ Email _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Other

Spouse or Parent/Guardian's Name _____

Person to contact in case of emergency _____ Phone # _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

If different from before mentioned person

Name of Person responsible for this account _____

Address _____ City _____ State_____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Relationship to Patient _____ Birth date_____ SSN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ Credit Card/Visa/MC ☐ Care Credit Finance Plan

INSURANCE INFORMATION

Please provide a copy of your dental card and supply subscriber information below if you are covered as a dependent

Name of Insured _____

Relationship to Patient _____ Birth date _____ SSN_____

Name of Employer _____ Work Phone _____

Insurance Company _____

Ins. Address _____ City _____ State ____ Zip _____

Employee ID# _____ Group # _____

PATIENT MEDICAL HISTORY

Patient Name: _____

General Physician _____ Year of Last Exam_____

1. Are you under any regular medical treatment now?*(e.g. chemo, diabetes)*..... ☐Yes ☐ No
2. Have you had any previous surgeries, please list below ..... ☐Yes ☐ No
   _____
3. Are you taking any medications including non-prescription medicine?..... ☐Yes ☐ No
   If yes, list medication(s) here or provide a list____ _____
   _____
4. Have you ever taken Fen-Phen/Redux?..... ☐Yes ☐ No
5. Have you ever taken Fosamax, Boniva, Actonel, **Reclast**, or any cancer medications containing bisphosphonates? (Circle the medication)..... ☐Yes ☐ No
6. Do you use Tobacco? ..... ☐Yes ☐ No
7. Do you use controlled substances? ..... ☐Yes ☐ No
8. Are you wearing Contact Lenses?..... ☐Yes ☐ No
9. Are you allergic to or have you had any reactions to the following?
   Local Anesthetics *(e.g. Novocain)* ..... ☐Yes ☐ No
   Any Metals *(e.g. nickel, mercury, etc.)*..... ☐Yes ☐ No
   Latex Rubber..... ☐Yes ☐ No
10. Are you allergic to or have you had any reactions to any Medications?..... ☐Yes ☐ No
    If yes, please list. _____
11. **Women Only:**
    Are you pregnant or think you may be pregnant? ..... ☐Yes ☐ No
12. **Do you have or have you had any of the following:**

High Blood Pressure	☐ ***Yes***	☐ ***No***	**Heart Attack**	☐ ***Yes***	☐ ***No***	**Arthritis**	☐ ***Yes***	☐ ***No***
Respiratory Problems	☐ ***Yes***	☐ ***No***	**Cardiac Pacemaker**	☐ ***Yes***	☐ ***No***	**Tuberculosis**	☐ ***Yes***	☐ ***No***
Rheumatic Fever	☐ ***Yes***	☐ ***No***	**Fainting/Seizures**	☐ ***Yes***	☐ ***No***	**Stroke**	☐ ***Yes***	☐ ***No***
Stomach Troubles	☐ ***Yes***	☐ ***No***	**Kidney Disease**	☐ ***Yes***	☐ ***No***	**Anemia**	☐ ***Yes***	☐ ***No***
Joint Replacement	☐ ***Yes***	☐ ***No***	**Diabetes**	☐ ***Yes***	☐ ***No***	**Cancer**	☐ ***Yes***	☐ ***No***
Date of replacement_____			**Epilepsy/Convulsions**	☐ ***Yes***	☐ ***No***	**Liver Disease**	☐ ***Yes***	☐ ***No***
Glaucoma	☐ ***Yes***	☐ ***No***	**Aids/HIV Infection**	☐ ***Yes***	☐ ***No***	**Thyroid Problem**	☐ ***Yes***	☐ ***No***
						Other _____		

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing? ☐ Yes☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes☐ No
4. Do you feel pain to any of your teeth? ☐ Yes☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes☐ No
7. Have you ever experienced any of the following problems in your jaw?
   a). Clicking ☐ Yes☐ No
   b). Pain (joint, ear, side of face) ☐ Yes☐ No
   c). Difficulty in opening, closing or chewing ☐ Yes☐ No
8. Do you have frequent headaches? ☐Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes☐ No
11. Have you ever had any difficult extractions in the past? ☐ Yes☐ No
12. Have you ever had prolonged bleeding after extractions? ☐ Yes☐ No
13. Have you had any orthodontic treatment? ☐ Yes☐ No
14. Do you wear dentures or partials? ☐ Yes☐ No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes☐ No
16. Do you like your smile? ☐ Yes☐ No

Authorization and Release

Payment is due in full at the time of treatment. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment, with my informed consent.

_____

Signature of patient (or parent/guardian if minor) ***Date*** *Revised September 2018*

Written Financial Policy

Thank you for choosing Walnut Ranch Dental Spa!

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering payment options.

Payment Options

PAYMENT IS DUE AT TIME SERVICES ARE RENDERED.

You can choose from:

(1) Cash, Check, Visa, MasterCard, or Discover

(2) *NO INTEREST Payment Plans from* ***CareCredit™*** *- Ask the business team for more information!*

New

- We will divide total treatment cost by the number of visits you will have to make it easier for you. Qualifying is by review.
- A 5% courtesy will be extended to those who want to pay for total treatment up front. We will still prepare and file your insurance for you and they will reimburse you directly. For those who do not have insurance the discount is still offered.

*The above mentioned "New" options are intended for comprehensive treatment and not for preventative services like your cleanings, routine exams, and x-rays.

Please note:

For larger, more comprehensive treatment plans of ***$400* or more,** a *deposit* is required to secure your initial treatment appointment. **Deposit is non-refundable** if cancellation or change in appointment is not given ***48 hours prior to treatment.***

Dr. Treanor requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

A Fee of $25, per appointment, is charged for patients who miss or cancel an appointment ***within 48* hour notice**. If you incur more than two (2) consecutive missed, cancelled, or rescheduled appointments or if Dr. Treanor deems your actions as not justified pre-payment arrangements will need to be discussed.

Dr. Treanor charges *$25* for Returned Checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and/or need.

Patient, Parent or Guardian Signature Date

Patient Name *(Please Print)* *Revised September 2018*

Walnut Ranch
DENTAL SPA
Joseph Treanor, DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Joseph Treanor, D.D.S. is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by *Joseph Treanor, D.D.S.* or received by *Joseph Treanor, D.D.S.* from other healthcare providers. We are required to provide you with notice of our legal duties and privacy practices with respect to you protected health information. These legal duties and privacy practices are described in this notice.

Joseph Treanor, D.D.S. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use of your protected health information.
Joseph Treanor, D.D.S. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time. Please request the Notice.

Uses and Disclosures of Your Protected Health Information not, Requiring Your Consent
Joseph Treanor, D.D.S. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on used and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:
- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, *Joseph Treanor, D.D.S.* may determine that you require the services of a specialist. In referring you to another doctor, *Joseph Treanor, D.D.S.* may share or transfer your healthcare information to that doctor.

Payment activities may include:
- Activities undertaken by *Joseph Treanor, D.D.S.* to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, *Joseph Treanor, D.D.S.* will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis and the services provided to you.

Healthcare operations may include:
- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, *Joseph Treanor, D.D.S.* may use your diagnosis, treatment, and outcome information to measure the quality of services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Joseph Treanor, D.D.S. may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when *Joseph Treanor, D.D.S.* is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law;

In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is a reasonable cause to believe that the wound occurred as a result of a crime.

For public health activities;

We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

This notice prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520 and applicable Oklahoma privacy laws.

Joseph Treanor, D.D.S.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received and reviewed a copy of *Joseph Treanor, D.D.S.* Notice of Privacy Practices. This Notice describes how *Joseph Treanor, D.D.S.* may use and disclose my, protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient or Personal Representative Date

_____

Relationship to patient