

WELCOME

Thank you for selecting Briter Dental. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for Yourself Your Child

Patient Full Name _____ Social Security # _____
Birth Date _____ Age _____ Male Female Single Married Other
Driver's License # _____ State _____ Exp Date _____
Address _____ City _____ State _____ Zip _____
Full Time Student _____ Yes No School Name _____
Employer _____ Occupation _____
Previous Dentist _____ Previous Dentist Phone _____
Current Physician _____ Current Physician Phone _____

2) TELEPHONE & EMAIL

Home Phone _____ Work Phone _____ Cell Phone _____
Email _____ Best time to call _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____
Home Phone _____ Work Phone _____

3) RESPONSIBLE PARTY

Who is responsible for this patient

Full Name _____ Social Security # _____
Birth Date _____ Age _____ Male Female _____
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Home Phone _____ Work Phone _____

4) INSURANCE INFORMATION

Dental Coverage Yes No

Insured's Name _____ Relation _____
Insured's Social Security # _____ Birth Date _____
Insurance Group # _____ Insurance Policy # _____
Insurance Co. Name _____ Insurance Co Phone _____

5) DENTAL HISTORY

Why have you come to the dentist today? _____

Date of last Dental Visit: _____

Do you require premedication before dental treatment? Yes ___ No ___
Are you currently in pain? Yes ___ No ___
Do your gums ever bleed? Yes ___ No ___
Have you ever had difficulties associated with any previous dental work? Yes ___ No ___
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)? Yes ___ No ___
Have your tonsils or adenoids been removed? Yes ___ No ___
Do you floss on a regular basis? Yes ___ No ___

6) MEDICAL HISTORY

Do you consider yourself in good medical health? Yes ___ No ___
Have you had previous skin reactions to jewelry or know of an allergy to any metal? Yes ___ No ___
Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes ___ No ___
Have you been hospitalized or had a serious operation or illness within the last 5 years? Yes ___ No ___

Are you taking any medications?..... Yes__ No__

If so, please list here? _____

Are you allergic to any of the following?

- Penicillin Codeine Aspirin Lidocaine or Marcaine
- Nitrous oxide gas Iodine Dental anesthetics Erythromycin
- Latex Other: _____

Have you ever had any of the following medical problems? Please check those that apply:

- Abnormal bleeding Fainting or Dizzy Spells Kidney Problems
- Alcohol / Drug abuse Frequent Headaches Liver Disease / Problems
- Anemia Glaucoma Low Blood Pressure
- Arthritis Hay Fever Nervous Disorder
- Artificial Joint Heart Attack or Disease Pacemaker
- Asthma Heart Murmur / Surgery Rheumatic Fever
- Cancer or Leukemia Hemophilia Seizures or Epilepsy
- Diabetes Hepatitis Shingles
- Difficulty Breathing Herpes / Fever Blisters Sinus Problems
- Emphysema High Blood Pressure Stroke
- Epilepsy HIV Positive / AIDS Thyroid Problems
- Ulcers Venereal Disease Stomach Problems
- Blood Disorders Tumors Steroids
- Implants Heart Failure Tuberculosis (TB)
- Artificial Heart Valve Cough Bruise easily
- Blood Transfusion Sickle Cell Disease Cold Sores
- Angina Pectoris Congenital Heart Lesions Scarlet Fever
- Hepatitis A (Infectious) Hepatitis B (Serum) Psychiatric Treatment
- Yellow Jaundice STD/ Syphilis, Gonorrhea
- Other _____

Women only:

Are you currently pregnant?..... Yes__ No__

If so, how many weeks? _____

Are you nursing Yes__ No__

Are you taking birth control Yes__ No__

7) REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient, friend Relative Work
 School Dental Office Yellow Pages Newspaper Other:

Name of person or office referring you to our practice:

8) ACKNOWLEDGEMENT & AUTHORIZATION

The undersigned hereby authorized Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorized Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated with (name of Patient) _____ and further authorize and consent that Doctor choose and employ such as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ **DATE** _____

Financial Policy

Thank you for choosing Briter Dental as your dental provider. We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities. The following is a statement of our Financial Policy; please take the time to read the below prior to your treatment.

Payments: We accept payment by CASH, CHECK, MONEY ORDER, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, CARE CREDIT. PAYMENT IS EXPECTED ON THE DAY OF TREATMENT. Any checks returned due to insufficient funds must be paid within five business days and will incur a \$25 returned check fee. Any checks returned for being written on a closed account will be forwarded to the State Attorney and the account immediately sent to collection.

Insurance: All benefits and coverage are contracted through the patient and insurance company directly and are no way a guarantee of payment. Majority insurance companies provide fee schedules so itemization of treatment is pre-determined by insurance. It is the patient's responsibility to contact their insurance company to make sure we are in network. If you have a secondary policy you will fill it out and we will provide all the necessary paperwork that you may require. Patient must provide valid insurance information at the time of treatment. Based on the information provided by the patient Briter Dental staff verifies all dental coverage and benefits. All claims are filed to the primary insurance provider. If for any reason claims are left unsettled or rendered not payable by the insurance company, patient must take full responsibility for any charges pertaining to treatment received through Briter Dental. As a service to our patients, we will bill insurance companies for services and allow them 45 days to render payment. After 60 days, you are completely responsible for the entire balance and it will be due in full. Please note that some procedures and treatments may be non-covered services and not considered reasonable and necessary under dental insurance. Some procedures may require co-pays and or deductibles that must be paid in full along with the treatment.

Cash pay: If you do not have dental insurance coverage, we offer Care Credit payment plans. Please ask for an application at the front desk.

Referrals: It is the patient's responsibility to obtain the referrals.

Consent for appointment confirmation – I hereby give Dr. Alvandi and Staff permission to confirm appointments using the phone number(s) I have provided, to include leaving messages.

- Leave a message on answering machine
- Leave a message on cell phone
- Leave a message with family members
- Leave a message at work
- Leave a message directly with patient

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 in cash at the time services are performed.

Once appointment has been made, I am aware that this time has been reserved especially for me. If I miss my reserved appointment, I fully understand that I pay \$50 for every 1 (one) hour appointment time I miss. At least 24 hours cancellation or to reschedule an appointment is required to avoid the \$50 fee.

Thank you for taking the time to read our Financial Policy. Please let us know if you have any questions or concerns.

I, _____, have read the Financial Policy in completion, agree to abide, and understand all the parameters within the agreement. By signing this agreement I give consent for Briter Dental to file claim with the insured party's insurance company.

Patient / Parent / Guardian

Date

Briter Dental, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Document****

I have read and received a copy of this office's Notice of Privacy Practices.

(Print Name)

(Signature)

(Date)

For Office Use Only

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

- Individual refused to sign
- Communication barrier prohibited obtaining patient's signature
- An emergency situation prevented us from obtaining patient's signature
- Other (Please Specify)

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice, at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional

judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, the cost of a duplicate panoramic x-ray is \$10.00, 1 x-ray (PA or BW) \$10.00, 2-6 x-rays (PA or BW) \$15.00, 7 or more x-rays (PA or BW) \$25.00, 1page \$10.00, 2-6 pages \$15.00, and 7 or more x-rays \$25.00.

Note: you will need to pay in advance and your copies will be ready in two business days. (No exceptions).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.