PERIODONTAL SPECIALISTS

Thomas L. Bradshaw, DDS
Donald G. Echols, DDS
Diane Quinn, RDH

754 South Main, Suite 7 Saint George, Utah 84770
Phone: 435-652-1605
Fax: 435-652-2046
www.gumexpert.com
bradshawdds@gmail.com

WELCOME TO OUR OFFICE. WE ARE COMMITTED TO PROVIDING THE BEST, MOST COMPREHENSIVE CARE POSSIBLE. WE ENCOURAGE YOU TO ASK QUESTIONS. PLEASE ASSIST US BY PROVIDING THE FOLLOWING INFORMATION. ALL INFORMATION IS CONFIDENTIAL AND IS RELEASED ONLY WITH YOUR CONSENT.

Health History

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you with the best care possible.

General Information

First name - Patient _____

Middle name _____

Last name - Patient _____

Patient birth date _____

Gender _____

Contact Information

Email address _____

Work # _____

Mobile # _____

Home # _____

Preferred contact method (Circle)

Cell Phone Work Phone Home Phone Email Mail

Patient mailing address _____

_____

Patient billing address _____

_____

Emergency Information

Emergency contact _____

Emergency # _____

Other Information

Social Security number _____

Occupation _____

PERIODONTAL SPECIALISTS

Dental Information

Were you referred to this office? If Yes, please tell us who referred you?_____

- ☐ Have you had any periodontal (gum) treatment?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Does food or floss catch between your teeth?
- ☐ Do you grind your teeth?
- ☐ Do you have any sores or ulcers in your mouth?
- ☐ Do you wear partial dentures?
- ☐ Have you had any problems associated with previous dental treatment?
- ☐ Are you currently experiencing dental pain or discomfort?
- ☐ Are your teeth sensitive to cold, hot, sweets, or pressure?
- ☐ Have you ever had orthodontic (braces) treatment?
- ☐ Do you have any clicking, popping or discomfort in your jaw?
- ☐ Have you ever had a serious injury to your head, neck or mouth?
- ☐ Do you wear full dentures?

Medical Information

Allergies

- ☐ Acetaminophen/ Tylenol®
- ☐ Codeine
- ☐ Food
- ☐ Latex
- ☐ Penicillin
- ☐ Acrylic
- ☐ Demerol
- ☐ Hay fever/ seasonal
- ☐ Local anesthetic
- ☐ Sulfa
- ☐ Animals
- ☐ Erythromycin
- ☐ Ibuprofen/ Motrin®/ Advil®
- ☐ Metals
- ☐ Tetracycline
- ☐ Aspirin
- ☐ Fluoride
- ☐ Iodine
- ☐ Morphine
- ☐ Other_____ _____

Conditions

- ☐ Abnormal/ Excessive Bleeding
- ☐ Angina
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cardiovascular disease
- ☐ Damaged heart valves
- ☐ Epilepsy
- ☐ GERD Reflux/ persistent heartburn
- ☐ Heart attack
- ☐ Hepatitis, jaundice or liver disease
- ☐ Low pain tolerance
- ☐ Night sweats
- ☐ Persistent swollen glands in neck
- ☐ Rheumatic heart disease
- ☐ Sexually transmitted infection (STI)
- ☐ Thyroid problems
- ☐ AIDS or HIV infection
- ☐ Anxiety
- ☐ Autoimmune disease
- ☐ Breathing problems/ respiratory disease
- ☐ Chest pain upon exertion
- ☐ Diabetes
- ☐ Fainting spells or seizures
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Malnutrition
- ☐ Osteoporosis/ Paget's disease
- ☐ Psychiatric care
- ☐ Rheumatoid arthritis
- ☐ Sinus trouble
- ☐ TMJ Disorder
- ☐ Alzheimer's/ dementia
- ☐ Arteriosclerosis
- ☐ Back problems
- ☐ Bronchitis
- ☐ Chronic pain
- ☐ Eating disorder
- ☐ Frequent headaches
- ☐ Gout
- ☐ Heart rhythm disorder
- ☐ Kidney problems
- ☐ Mitral valve prolapse
- ☐ Other congenital heart defects
- ☐ Recurrent Infections
- ☐ Severe headaches/ migraines
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood disease
- ☐ Cancer/chemotherapy/ radiation treatment
- ☐ Congestive heart failure
- ☐ Emphysema
- ☐ Gastrointestinal disease
- ☐ Hearing difficulties

PERIODONTAL SPECIALISTS

- ☐ Hemophilia
- ☐ Low blood pressure
- ☐ Ulcers
- ☐ Other
- ☐ Neurological disorders
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Severe or rapid weight loss
- ☐ Systemic lupus erythematosus
- ☐ Tumors or growths

Explain _____

Do You have any disease, condition or problem that is not listed that you think we should know about?

_____

☐ Are you taking any prescription or over-the-counter medicines? If so, please provide a printed copy or list below. Including vitamins, natural or herbal preparations and/or diet supplements.

_____

_____

☐ Has there been any change to your general health within the past year? If Yes, what condition is being treated?

_____

☐ Have you had a serious illness, operation or been hospitalized in the past 5 years?

_____

_____

_____

_____

☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

_____

☐ Do you use tobacco (smoking, snuff, chew, bidis)?

_____

☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

☐ Are you taking birth control or hormone replacement?

☐ Do you have sleep apnea?

☐ Have you ever reacted adversely to any medications or injections?

☐ Do you drink alcoholic beverages?

_____

☐ Are you wearing a nicotine patch?

☐ Are you pregnant? If yes, Number of weeks?

_____

☐ Are you nursing?

☐ Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?

Family doctor:

_____Family doctor # _____

Date of last physical exam: _____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Signature _____

I agree that the information provided in this form is correct to the best of my knowledge.

PERIODONTAL SPECIALISTS

Thomas L. Bradshaw, DDS
Donald G. Echols, DDS
Diane Quinn, RDH

HIPPA Notice of Privacy Practices

HIPAA NOTICE OF PRIVACY PRACTICES As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as−needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility.

We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers’ Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

PERIODONTAL SPECIALISTS

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

HIPPA Notice of Privacy Practices

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

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 questions concerning or objections to this form, please ask to speak with Dr Bradshaw in person or by phone at (435) 652-1605. Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

☐ Acknowledged practice privacy practices

Signature _____ Date _____

PERIODONTAL SPECIALISTS

Thomas L. Bradshaw, DDS
Donald G. Echols, DDS
Diane Quinn, RDH

Primary Dental Insurance Information

While we are pleased to be of service by processing your dental claim for you, we are not responsible for any limitations in coverage that may be included in your dental insurance plan. If your dental plan denies your claim for any reason, you are responsible for your bill in its entirety.

Primary Dental Insurance Company's Name:

_____

Subscriber's Name: Subscriber's Birth Date:

_____ _____

Subscriber's Social Security# Relationship to Patient:

_____ _____

Insurance Group #: Subscriber/ Member ID#:

_____ _____

Insurance Phone #: Subscriber's Employer:

_____ _____

Insurance Company Address: Insurance Company Payer ID#

_____ _____

_____

City State Zip Code

_____ _____ _____

Secondary Dental Insurance Information

Secondary Dental Insurance Company's Name:

_____

Secondary Insurance Subscriber's Name Secondary Insurance Subscriber's Date of Birth

_____ _____

Secondary Insurance Subscriber's Social Security #: Secondary Insurance Subscriber's Relationship to Patient

_____ _____

Secondary Insurance Group # Secondary Insurance Subscriber's Member ID#

_____ _____

Secondary Insurance Phone #: Secondary Insurance Subscriber's Employer:

_____ _____

Secondary Insurance Address Secondary Insurance Payer ID#

_____ _____

_____

City State Zip Code-

_____ _____ _____

NOTICE:
Dr. Bradshaw and Dr. Echols are contracted insurance providers for: Delta Dental and Select Health Dental (Classic Plan).
If you have a different dental insurance company, we will bill them for you, but we are not contracted to their fee schedule. Your benefits and coverage will be paid differently in our office.

Authorization to Release Information
I hereby authorize any provider, Insurer or other organization to release any information regarding the dental history, treatment or benefits payable for this claim to the plan administrator or its authorized agent for purpose of determining benefits payable.

Signature Date

_____ _____

PERIODONTAL SPECIALISTS

Thomas L. Bradshaw, DDS
Donald G. Echols, DDS
Diane Quinn, RDH

Financial Policy

Welcome to Periodontal Specialists. We are happy to have you as a patient and look forward to offering you exceptional care. We know that providing complete and comprehensive periodontal services, includes discussing all treatment and financial information. Before treatment is performed, we will discuss treatment and financial obligations so you will know what to anticipate in fees.

If you do not have insurance:

Payment is due in full at the time of service. For your convenience we accept cash, checks, Visa, MasterCard, Discover Card, American Express, and Care Credit.

If you have DENTAL insurance:

In network: (Select Health Classic Plan, Delta Dental) 20% is due at the time of service.
Out of network: 50% is due at the time service.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment, it often does not cover all the costs involved in treatment. As a courtesy, we will be happy to file a dental claim for you if you present your dental insurance card and all required employer information. You will be expected to pay for services rendered if this office is unable to verify your insurance information. If payment for services already rendered has not been paid in full within 45 days, either by you or by your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

A service charge of 18% per month on the unpaid balance will be charged on all accounts exceeding 30 days. When accounts have exceeded 90 days, we reserve the right to report the account to a collection agency. The undersigning specifically agrees to pay all reasonable attorney's fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collections.

Appointments are reserved exclusively for you. If you are unable to keep your appointment, please let us know at least 48 hours in advance. If 48 hours notice is not given, we reserve the right to charge a seventy-five dollar ($75) cancellation fee.

By signing this financial policy, you are acknowledging you have read and understand the terms and conditions of this agreement.

_____	_____	_____
Printed Name	Signature	Date