Confidential Patient Medical History

Please Print

First Name	MI	Last Name	Nickname	Today's Date
Address			Apt #	Date of Birth (required)
City		State	Zip	Social Security Number
Home Phone	Work Phone	Cell Phone	Marital Status S M D W	Sex M F
				Spouse's Name
Physician Name	Address		Physician Phone	Employer / college
Pharmacy Name	Address		Pharmacy Phone	Your Email Address
Name and Address of person we can contact in case of emergency (other than your family home)				Phone

How did you hear about us?		Other family members seen here:	
If female, please answer the following:		**Everyone please answer the following:**	
Y N	Are you taking birth control? What kind?	Please circle one: Smoker Chew tobacco Neither How much do you use?	
Y N	Are you pregnant or trying to get pregnant? If yes, how many weeks along?	Height	Weight
Y N	Are you nursing?	BP	Heart Rate

Please Circle Y (yes) or N (no) – Do Not Leave Any Areas Blank

Abnormal Bleeding	Y N	Frequent Headaches	Y N	Sickle Cell Disease	Y N
Alcohol Abuse History	Y N	Glaucoma	Y N	Sinus Problems	Y N
Allergies	Y N	Hay Fever	Y N	Sleep Apnea (Snoring)	Y N
Anemia (Low Iron)	Y N	Heart Attack	Y N	Stroke	Y N
Angina (Chest Pain)	Y N	Heart Surgery	Y N	Thyroid Problems	Y N
Arthritis	Y N	Hemophilia	Y N	Tuberculosis	Y N
Artificial Joints	Y N	Hepatitis A	Y N	Ulcers	Y N
Artificial Heart Valve	Y N	Hepatitis B	Y N	Venereal Disease	Y N
Asthma	Y N	High Blood Pressure	Y N	Yellow Jaundice	Y N
Blood Transfusion	Y N	HIV or AIDS	Y N	**ALLERGIES**	
Cancer / Chemotherapy	Y N	Kidney Problems	Y N	Aspirin	Y N
Colitis (Irritable Bowel)	Y N	Liver Disease or Hepatitis C	Y N	Codeine	Y N
Congenital Heart Defect	Y N	Low Blood Pressure	Y N	Dental Anesthetics	Y N
Cosmetic Surgery	Y N	Mitral Valve Prolapse	Y N	Erythromycin	Y N
Diabetes	Y N	Pace Maker	Y N	Jewelry	Y N
Drug Abuse History	Y N	Psychiatric Problems	Y N	Latex	Y N
Emphysema	Y N	Radiation	Y N	Metals	Y N
Epilepsy	Y N	Rheumatic Fever	Y N	Penicillin	Y N
Fainting Spells	Y N	Seizures	Y N	Tetracycline	Y N
Fever Blisters	Y N	Shingles	Y N	Other:	

Signature **Date**

List Your Medications

☐ ***Check this box if you are <u>NOT</u> taking any type of medications***

_____
_____
_____
_____
_____
_____

☐ ☐ ***Y N*** ***Is there any disease, condition or problem that you think this office should know about that is not covered above? If yes, please describe below.***

_____
_____
_____
_____
_____

Bisphosphonates Informed Consent

Any dental procedures performed including but not limited to extractions, Endodontics, orthodontics, and any surgical procedure may cause bone and/or infection complications including but not limited to bone necrosis as a result of these medications.

Please check if you have taken or been treated with the following drugs for osteoporosis or metastatic bone cancer:

- ❑ Etidronate (Didronel)
- ❑ Alendronate (Fosamax)
- ❑ Pamidronate (Aredia)
- ❑ Ibandronate (Boniva)
- ❑ Zoledronic Acid (Zometa)
- ❑ Riseddronate (Actonel)
- ❑ Fosamax (Alendronate Sodium)
- ❑ Boniva (Ibandronate Sodium)
- ❑ Actonel (Risidronate)
- ❑ Pamidronate IV
- ❑ Zolendronate IV
- ❑ Bonefos
- ❑ Fosamax Plus D
- ❑ Skelid

❑ I have been treated for metastatic bone cancer.

_____ _____

Patient / Guardian Signature **Date**

_____

Print Patient Name

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Lifetime Dental Care. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) 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 because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Lifetime Dental Care
Anthony Butchert D.D.S,

822 South Hastings Way ◆ Eau Claire, WI 54701 ◆ (715) 552-1000

PATIENT FINANCIAL POLICY

1 For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. Please note that your insurance contract exists solely between you and your insurance carrier. **We will file your insurance claim, but we cannot guarantee any benefits**. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. **Ultimately, you are responsible for the entire cost of your dental treatment.** In some cases, if you do have insurance coverage, we may still ask you to pay in full on the date of service. Any questions or comments regarding your benefits should be directed to your insurance carrier. If the balance is not cleared within 60 days, you will be charged a billing fee of $5.00 monthly.

2 **Payment at the time of service is expected, or the estimated portion of the amount that insurance does not cover**. Our office accepts the following credit cards: MasterCard, VISA, American Express, Discover and Care Credit. There is a prepay 10% reduction in fees for your next appointment when you make the appointment if paid in full with cash or check at the time of *scheduling* treatment. Sedation appointments, "Invisalign", and credit card payments are excluded from the 10% offer. *Also excluded are patients with PPO contracts due to the contractual discounts in their policies. (Sedation appointments require pre-payment, Invisalign requires $610.00 non-refundable deposit before sending out case. Some of the Invisalign fee may or may not be reimbursed by your insurance depending upon your policy parameters.)*

3 When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 60 days, a billing fee of $5.00 per month will be charged on all outstanding balances regardless of estimated insurance.

4 A credit qualification will be researched on each new patient before being offered payment arrangements.

5 A statement for services rendered will be mailed to you every four weeks. Receipt of payment is expected within 21 days of the postmark. The patient's payment should be mailed with the top portion of the statement to establish the proper crediting of the account.

6 Your account due is considered delinquent if the requested payment is not received 21 days after billing. If payment is not received, a billing fee of $5.00 per month will be assessed after 60 days, and will appear on the next statement. All fees are subject to change without a new form's being signed.

7 A $35.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.

8 There will be no charge for a broken appointment with 24 hours' notice. This enables us to fill the reserved time slot from our list of patients who are able to come on short notice. **Broken appointments with less than 24 hours' notice will incur a fee of $45.**

9 Before records can be transferred, you must sign a privacy release form and pay the $28.00 x-ray duplicating fee if needed.

10 Delinquent accounts after 90 days may be sent to a collection agency or small claims court. **Any fees incurred for the collection of a debt are the responsibility of the patient or guarantor and will be added to the account.**

I have read and understand the financial policy of Dr. Tony Butchert and agree to all the terms described in it.

_____ Date_____
Patient Signature/Guardian Signature

_____
If signed by Guardian, please print patient's name above.

Patient Dental Questionnaire

1. What is your main dental concern? _____
2. How many years since your last dental exam?_____
   Since your last dental x-rays? _____
3. Please circle your biggest reasons for avoiding the dentist.
   (circle one) ***Fear Expense No Time Nothing Wrong Don't Trust I Don't Avoid the Dentist***
4. Does tooth discomfort wake you at night? ***Yes - No***
   Are you taking pain pills for any discomfort? ***Yes - No***
   *If yes, what are you taking?*_____
   Are they working? ***Yes – No***
5. Are your teeth sensitive to…?
   (circle one) ***Hot - Cold - Chewing - After a Cleaning - After Fillings – Nothing***
6. Do you have a bad taste or bad breath? ***Yes - No***
7. How often do you floss? _____
8. How often do you brush? _____
   Brush Type: ***Soft - Medium - Hard***
9. Do your gums bleed, do you see pink after brushing? ***Yes – No***
10. If you could have it any way, how many more years would you like to have your teeth?
    (circle one) ***Lifetime 20 yrs 10 yrs Not At All***
11. Would you like a 5 year warranty on any procedure for an extra 10% premium? ***Yes – No***
12. Have you had braces or retainers? ***Yes - No***
13. Would you like whiter teeth? ***Yes - No***
14. Would you like straighter teeth? ***Yes – No***
15. Would you like your smile to look different? ***Yes – No***
16. How many cups of coffee a day do you drink? _____
    With cream? _____ Sugar? _____
17. How many cans of soda? _____ Brand _____
18. Do you chew gum daily? ***Yes – No***
19. Does your jaw snap, click, or pop? ***Yes – No***
20. Do you clench your teeth? ***Yes – No***
21. Has anyone heard you snoring at night? ***Yes - No***
22. Do you get headaches weekly? ***Yes – No***
23. Have you ever awakened with a headache? ***Yes – No***
24. Do you use tobacco products? ***Yes – No***
25. Do you sweat or tremble during examination? ***Yes – No***
26. Do strange people or places make you afraid? ***Yes – No***
27. Do you consider yourself a touchy person? ***Yes – No***
28. Are you unhappy or depressed? ***Yes – No***
29. Are you easily upset or irritated? ***Yes – No***
30. How did you choose this office? ***Location - Sign - Postcard - Yellow Pages - Mailing - Internet - Newspaper– Magazine - Insurance – Other***_____

On a scale of 1-10 with 10 the highest rating, *please circle one.*

	Not Important At All									Highly Important
How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
	Very Unhealthy									Incredibly Healthy
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where would you like to see your dental health 5-10 years from now?	1	2	3	4	5	6	7	8	9	10
	Nothing At All									Pays Everything
What do you perceive your insurance benefits to pay?	1	2	3	4	5	6	7	8	9	10

_____ _____ Date_____

Patient/Guardian Signature Print Patient Name