BURBA DENTAL PARTNERS
Advanced Cosmetic Dentistry
Dr. Randy Burba, D.M.D & Dr. Stanley Burba, D.D.S

PATIENT INFORMATION

Name: _____ Date of Birth ____/____/_____ Social Security # ____-____-____

Address:_____ City:_____ State:_____ Zip:_____

Telephone number: ( ) Email:_____

Physician:_____ Tel. #( ) -

Pharmacy: _____ City/Town:_____

Emergency Contact **AND** Relationship to you: _____ Tel.#( ) -

INSURANCE INFORMATION

Do you carry dental insurance? Yes No Through your: SELF or SPOUSE or PARENT

Insurance Company:_____ Insured Name: _____

Insured S.S. # _____-_____-_____ Insured Date of Birth: _____/_____/_____ Insured Employer:_____

Group # _____ Insurance ID # _____

MEDICAL INFORMATION

Please List **ALL** Medications Currently Taking: Or please provide us with a list we can take a copy of

Medication:	Medical Condition:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have or have had any of the following problems: **Please check all that apply**

__Abnormal Bleeding
__Alcohol Abuse
__Allergies
__Anemia
__Angina Pectoris
__Arthritis
__Artificial Bones
__Artificial Heart
__Asthma
__Blood Transfusion
__Caner/Chemo/ Radiation
__Colitis
__Congenital Heart
__Cosmetic Surgery
__Diabetes
__Difficulty Breathing
__Emphysema
__Epilepsy
__Fainting Spells

__Fever Blisters
__Frequent Headaches
__Glaucoma
__Hay Fever
__Heart Attack/Year:_____
__Heart Surgery
__Hemophilia
__Hepatitis A/B/C
__High Blood Pressure
__Low Blood Pressure
__HIV/AIDS
__Kidney Problems
__Liver Disease
__Mitral Valve Prolapse
__Pace Maker
__Pneumocys
__Psychiatric Problems
__Rheumatic Fever
__Seizures

__Shingles
__Sickle Cell Disease
__Stroke/Year:_____
__Thyroid Problems
__Tuberculosis
__Ulcers
__Venereal Disease
__Yellow Jaundice
__Other:
_____
_____
_____
_____
_____
_____

Any Allergies:
__Local Anesthetic
__Penicillin
__Sulfa
__Aspirin
__Codeine
__None
__Other:
_____
_____

Do you take any:
__Vitamin E
__Regular/Baby Aspirin
__Blood Thinner

Have you in the past 6 months had:
__Stroke
__Heart Attack
__In cancer treatment

Have you had any:
__Heart/Valve Issue
__Bone Replacement(s)
__Endocarditis

Do you need to Premedicate for the above?
__Yes __No

What antibiotic do you take for the premedication?:
_____

Have you had any serious problems associated with any previous dental treatment? _____

Do you (circle all that apply) Smoke? Grind your teeth? Snore? Have gums that bleed easily?

Patient/Guardian Signature: _____ Date _____/_____/_____

Protecting Your Confidential Health Information is Important to Us

Our Promise!

Dear Patient:
It is our desire to communicate
to you that we are taking the
new Federal (HIPAA- Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

So what has changed?
Why a privacy policy now?
Very good question!

The most significant variable that has motivated the Federal government to legally enforce the importance of privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used. We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valued patient.
We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your permission.

How your HEALTH INFORMATION may be used

To Provide Treatment
We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders
Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family telephone reminders or electronic reminders such as emails (unless you tell us that you do not want to receive these reminders).

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as emails (unless you tell us that you do not want to receive these reminders).

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Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment
Patient Name(s):_____
_____
_____
Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____
Patient Signature
Date_____/_____/_____

Patient Rights
This new law is careful to describe that you have the following rights related to your health information.

Restrictions
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.
Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.
We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.
You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of you information. Please let us know of you concerns or complaints in writing.

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ASSIGNMENT OF BENEFITS AND MY RESPONSIBILITY

I, _____understand that services rendered to me by Providers at Burba Dental Partners are **my financial responsibility** and that the Provider will bill my insurance company as a courtesy.

I authorize my insurance company to pay my benefits directly to Burba Dental Partners and I understand that **I will be fully responsible for any outstanding balance on my account**. This is a direct assignment of benefits under my policy.

I have been given the opportunity to pay my estimated deductible and co-insurance portion at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my Insurance Company policy.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will send the payment to Burba Dental Partners within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their money. Should the insurance company forward payment to me, or should I owe additional money after the claims for any treatment performed have been processed I agree to pay for any balances owed promptly or be subject to the collection process and any fees associated.

**In additional, to avoid inconvenience and additional fees, I may choose to authorize Burba Dental Partners to facilitate payment utilizing a credit card number on file to resolve balances owed: Yes or No*

Dated_____

Witness_____

Signature of Policyholder/ Patient /Guardian and Printed Name

_____ _____

BURBA DENTAL PARTNERS

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Our Limited Warranty

Here at Burba Dental Partners we are proud of the services and care we provide our patients. We are concerned not only with your current dental problems but also your long term dental health. We will provide you with treatment that is based on the most up-to-date research, the best skills, the best materials and the best service. You will be shown how to properly protect and care for your teeth and gums so you can avoid dental disease in the future. Together we work to ensure that you not only maintain dental health, but also provide you with the opportunity to have a smile you will be proud to show the world. Given these goals, we at Burba Dental promise to stand behind our treatment and our services to the very best of our abilities. You as the patient will be expected to do your part by faithfully making and keeping recare appointments at the interval recommended by Dr. Burba and our hygienist (2, 3, 4 or 6 months). We, in turn, will warranty the following list of treatments:

Sealants: 3 years
Composite fillings: 3 years
Removable dentures and partial dentures: 3 years
Crowns, bridges, onlays, and porcelain veneers: 5 years

If any of the above treatments fail within the stated time period we will repair or replace if provided the patient has faithfully maintained his or her personalized recare schedule. This warranty does not include damaged caused by trauma or obvious negligence by the patient.

This warranty is null and void if the patient does not maintain the recare schedule recommended by Dr. Burba and our hygienist or if the patient fails to utilize the procedures recommended by Dr. Burba for care and/or protection of the above.

_____ _____

Print Patient Name Date

_____

Signature of Patient

FINANCIAL PLANNING

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require that you read and initial prior to any treatment.

- **Full payment is due at the time of service** unless specific arrangements are made in advance.
- We accept Cash, Checks, MasterCard, Visa, Discover and American Express.
- Please inquire about Care Credit and our flexible payment options if you should need financing.

_____
Initials

USUAL AND CUSTOMARY RATES

Reminder: As a courtesy to our patients, we submit to your insurance company for payment for your treatment. Our practice is committed to providing the best treatment for our patients, therefore we do not allow insurance policies to dictate the costs of services performed at our office. Each patient has an insurance policy that is unique to their own allowed amounts, frequency limitations and guidelines. If a recommended service is more than allowed by your plan, or due an unforeseen clause in your plan which fails to make payment toward these services you will be responsible for the difference in price or lack of payment from your insurance benefits.

_____
Initials

MISSED APPOINTMENTS

We understand that emergencies may arise that require a change in the time reserved for you. We value the time reserved for our patients and require a **two-business day notice** prior to that change (please note that we are closed Saturday and Sunday). **Any appointment missed without notice or cancelled on the same day will be charged a fee of $50.00 per hour. (i.e. a two hour appointment cancellation will be charged a $100.00 cancellation fee.)**

After 3 missed appointments or short notice cancellations you will be inactivated as a patient. We will continue to provide you with emergency care for 30 days.

If a lengthy appointment is reserved for you and it is cancelled or missed, we will require a prepayment of your portion to secure another appointment for that procedure.

_____
Initials

I have read, understand and agree to the terms of the Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

This form asks if you have a family member or friend whom Burba Dental Partners is allowed to speak with regarding your health, insurance, and/ or billing if they call on your behalf. If you do, please fill out.

HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Standards

Print Patient Name: _____ Date of Birth: _____

My Authorization: I authorize the following using or disclosing party: Burba Dental Partners
To use or disclose the following health information: (please check all that apply)

___ All of my health information
___ My health information relating to the following treatment/ condition:
_____
___Other:

The above party (Burba Dental Partners) may disclose this information to the following recipient:
Name of person/ relation to patient: _____
Address: _____
City, State, Zip: _____
Phone:_____
Fax/Email:_____

The purpose of this authorization is (check all that apply)
___ At my request
___ Other:
_____
Does this authorization have an end date?
___No
___ Yes: Date when we can no longer disclose information to this person(s):_____

Signature of Patient: _____ Date:_____