BRANDON D. SMITH
KENNETH C. BARNEY, D.D.S.

WWW.DENTALARTSOFHEDGESVILLE.COM
Tel: 304-754-8803
Fax: 304-754-8039

ARTISTRY • INTEGRITY • PASSION

101 NORTH MARY STREET
HEDGESVILLE, WV. 25427

Patient Information & Demographics

Appt date _____ **Arrival time:** _____ **Appt time:** _____

Name: _____ MI: _____ Nickname: _____

Address: _____
City: _____ State: _____ Zip: _____
Date of birth: _____ Age: _____ SSN: _____
Drivers License _____ State: _____

Marital Status: ☐ Single ☐ Married Spouse name: _____

Student / School Name: _____

Place of employment _____
Can we contact you at work? ☐ Yes ☐ No Telephone: _____

Contact Information

Home: _____ Cell: _____
Email: _____

Emergency Contact: _____ Telephone: _____

Whom may we thank for referring you to our office? _____

Responsible Party & Family Information

Is any other family member a current patient of Dr Smith's ? ☐ Yes ☐ No
If yes who? _____

Please complete if patient is a minor:
Name of responsible party: _____
Relation to patient: _____ Date of birth: _____

Insurance Information

☐ On file ☐ NONE

Primary Insurance Name: _____
Subscriber: _____ Relation: _____
DOB: _____ ID / SSN: _____ Group #: _____
Group Name _____ Employer _____
Insurance Phone: _____ Insurance address: _____

Secondary Insurance Name: _____
Subscriber: _____ Relation: _____
DOB: _____ ID / SSN: _____ Group #: _____
Group Name _____ Employer _____
Insurance Phone: _____ Insurance address: _____

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Established pt update:_____

Chart:_____ DOB:_____ Patient Name:_____

Dental History

Reason for today's visit: _____
Previous dentist (optional): _____ Date of last visit: _____

	Yes	No		Yes	No
Dental problems	☐	☐	Regular dental care	☐	☐
Decay	☐	☐	Gum Disease	☐	☐
Jaw Pain / tiredness	☐	☐	Gums bleed	☐	☐
Floss	☐	☐	Clinch/ Grind teeth	☐	☐
Loose / broken teeth	☐	☐	Bad breath	☐	☐
Smoke / chew tobacco	☐	☐	Lip / cheek biting	☐	☐
Interest in improving smile	☐	☐	Interest in whiter teeth	☐	☐
Periodontal treatment	☐	☐	Orthodontic treatment	☐	☐
Headaches	☐	☐	Facial pain	☐	☐
TMJ pain/noise (clicking, popping)	☐	☐	Tender sensitive teeth	☐	☐
Difficulty Chewing	☐	☐	Limited Opening	☐	☐
Neck pain	☐	☐	Ear Congestion	☐	☐
Postural problems	☐	☐	Dizziness	☐	☐
Ringing in the ears	☐	☐	Insomnia	☐	☐
Tingling/numbness in fingers	☐	☐	Nervousness	☐	☐
Hot / cold sensitivity	☐	☐	Back pain	☐	☐
Difficulty Swallowing	☐	☐	Trigeminal Neuralgia	☐	☐
Bell's palsy	☐	☐	Bad dental experience	☐	☐

Other: _____

Medical History

CIRCLE ALL that apply

AIDS	Chemotherapy	Heart Condition	Low BP
Anemia	Depression	Heart Murmur	MVP
Angina (chest pain)	Diabetes **Type:**_____	Heart Surgery	Nervousness
Arthritis	Dizziness	Hepatitis **Type**:____	Pacemaker
Artificial Heart Valve	Drug Addiction	HIV Positive	Rheumatic Fever
Artificial Joints	Emphysema	High Blood Pressure	Seizures
Asthma	Epilepsy	Jaundice	Sinus Problems
Blood Thinner	Excessive Bleeding	Jaw Joint Pain	Sleep Apnea
Bruise Easily	Fainting	Kidney Disease	Stroke
Cancer	Glaucoma	Liver Disease	*** **NONE** *** ☐
Other:			

Are you under a physician's care? ☐ Yes ☐ No Physicians Name: _____
Are you pregnant or trying? ☐ Yes ☐ No
Do you or have you used synthetic canabinoids *(synthetic marijuana, "spice", "K2", "fake weed")* ☐ Yes ☐ No
Any other information you would like us to know? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health history, I will inform the doctor at the next appointment

_____ _____
Signature Date

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Established pt update:_____

Patient Name:_____ DOB:_____ Chart:_____

Allergies

Please list ALL allergies and include a brief description of the reaction you have to it.

☐ I have no known allergies

Source of allergy		Reaction
☐	Penicillin	
☐	Codeine	
☐	Sulfa	
☐	Latex	
☐	Metals	
☐	Aspirin	
☐	Seasonal	
☐		
☐		
☐		
☐		
☐		

Medications

Please list ALL prescription *and* over-the-counter medications.

☐ I am not taking any medications

Please check either RX or OTC

Medication	Strength	How often	Date started	Reason for using	RX	OTC

Pharmacy:_____Telephone:_____

_____ _____
Signature Date

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Chart:_____

DOB:_____

Patient Name:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list any dependent children under the age of 18 also covered by this acknowledgement:

_____ _____
_____ _____

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

☐ NO ONE

Name:_____Relation to patient:_____

Name:_____Relation to patient:_____

Name:_____ Relation to patient:_____

☐ I give permission for the following communications to be used by Dr. Brandon D Smith DDS, (**please check all that apply**) : ☐Cell phone ☐Home phone ☐ Work ☐ E-mail:_____

☐ I am granting permission for Dr. Brandon D Smith DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. Brandon D Smith DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back

Signature: _____ ***Date:*** _____

RELATIONSHIP TO PATIENT: ☐*ADULT PATIENT* ☐*PARENT* ☐*GUARDIAN* ☐*OTHER*_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation
☐ Other – please list: _____

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CONSENT FOR SERVICES
PLEASE READ CAREFULLY

As a condition of your treatment by this office, this practice requires reimbursement from the patient for the costs incurred in their care. **All dental services performed must be paid in full at the time services are rendered if there is no dental coverage.** Patients who do not carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will extend the courtesy of preparing the insurance forms. We will assist in making collections from insurance companies and will credit any such collections to the patient's account if the insurance company sends benefits to the doctor. **Any portion not paid by the insurance is the responsibility of the patient and is due in full at the time services are rendered.** Ultimately, the amount paid by insurance is determined by the insurance carrier based on information that may not be disclosed to our office. **We at no time guarantee what your insurance will or will not pay with each claim**. **Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than estimated, the unpaid balance is due from the patient.**

Account balances that exceed 90 days will receive a service charge of 1 ½% per month (18% per annum) on the unpaid balance.

I understand that the fee estimate listed for dental care can only be extended for a period of six month from the date of the patient examination.

I have read the above conditions of treatment and agree to their content.

_____ _____ _____
Signature Date Relationship

Insurance Patients: Please read and sign below

I authorize release of information to the previously named insurance company/companies.

_____
Signature of insured person

I authorize payment directly to Dr. Smith of the Group Insurance Benefits otherwise payable to me.

_____
Signature of insured person

Thank you for taking the time to complete our form.
This will help us to be of greater service to you.

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Written Financial Policy- Please read carefully

Thank you for choosing Dr. Brandon D Smith DDS for your dental needs. 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 several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

Dr. Smith requires payment prior to the completion 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.[2] Dr. Smith **does not** participate or is in network with any dental insurance company so any balance unpaid by insurance is your responsibility.

Dr. Brandon D Smith DDS charges $35 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 or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Missed / No Show Policy

We at Dr. Smith's office put our faith in our patients to keep their scheduled appointments. When we set up an appointment, a specific amount of time is reserved especially for you. Many offices double or even triple book appointments to make up for missed appointments.

However, double booking an appointment does not allow us to give the care and attention needed to provide excellent quality dentistry and for this reason **we choose to not do this.**

We understand that circumstances arise that do not allow you to keep your appointment, if for any reason you must cancel or change your appointment please give our office **at least 48 hours notice** so that we may offer your appointment to someone else.

You may call the office any time even after normal business hours and leave a message or you may send an email to dentalartsorfhedgesville@gmail.com

- **Missed or No Show Appointments -** We reserve the right to charge a missed appointment fee of $60.00. This is an out of pocket expense for you that insurance **will not** cover.
- **Late cancellations** – late cancellations are appointments that are cancelled the same day the appointment is scheduled. We reserve the right to charge a $25.00 late cancellation fee.

This policy will not affect the majority of our patients, but must be included to ensure that missed appointments are kept to a minimum. If you have any questions regarding our policy please speak with a staff member and we will be happy to answer all questions.

I have read and understand the above policy, all questions have been answered and I agree to all listed terms.

_____ _____
Patient or Legal Guardian **PRINTED** name Date

_____ _____
Patient or Legal Guardian Signature Date

Thank you for taking the time to read our policy
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101 N. Mary Street – Hedgesville WV 25427
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Chart:_____

DOB:_____

Patient Name:_____

Consent to Text or Email for Appointment Reminders and other Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment and or provide other general communication/information. By signing below, I consent to receiving appointment reminders and other communication/information at the cell number and/or email address below.

_____(patient initials) I consent to receive text messaged from Dr. Brandon D Smith at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above.

_____ (patient initials) I **DO NOT** consent to receive text messages from Dr. Brandon D Smith DDS

The cell phone number that I authorize to receive text messages:

_____

The email address that I authorize to receive emails:

_____

This practice does not charge for this plan, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Please let us know what your preferred method of contact is:

☐ Telephone ☐ Text ☐ Email

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THE EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to dose off or fall asleep in the following situations?

	0	1	2	3
✓ **Please check one in each row:**	No chance	Slight chance	Moderate chance	High chance
Sitting and reading				
Watching TV				
Sitting inactive in a public in a public place (i.e. a theater or a meeting)				
Sitting and talking to someone				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting quietly after a lunch without alcohol				
In a car, while stopping for a few minutes in traffic				
TOTAL SCORE		*(add columns 0-3)*		

STOP QUESTIONNAIRE

(a quick questionnaire to see if you have an increased likeliness to have sleep apnea)

✓ **Please check either yes or no:**		**Yes**	**No**
S	Snoring – have you been told that you snore?		
T	Tired – Do you often feel tired, fatigued, or sleepy during the daytime?		
O	Observed – Do you know if you have stopped breathing or has anyone witnessed you stop breathing while sleeping?		
P	Pressure – Do you have high blood pressure or take medication to control high blood pressure?		

Have you ever had a sleep study? ☐ Yes ☐ No
Do you currently use a CPAP? ☐ Yes ☐ No

Patient name:_____ Age:_____ ☐ Male ☐ Female

Signature:_____Date:_____