Patient Registration Information

CONFIDENTIAL

Date ______________________

Name ______________________ SSN # ______________
First MI Last

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any question or concerns, please do not hesitate to ask for assistance - we will be happy to help.

Home address ______________ City ______________ State ______ Zip ______

Email ______________________________________

Birthdate ______________ Home phone ______________ Work phone ______________

Cell phone ______________ Do you prefer to receive ❑ Calls ❑ Text ❑ Email

Are you: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Whom may we thank for referring you? ______________________

Person to contact in case of an emergency ______________________ Phone ______________

Responsible Party

Name of person responsible for this account ______________ Relationship ______________

Address ______________________ Home phone ______________

City ______________ State ______ Zip ______ SSN # ______________

Birthdate ______________ Cell phone ______________

Employer ______________________ Work Phone ______________

Is this person currently a patient in our office? ❑ Yes ❑ No

Insurance Information

Name of insured ______________________

Relationship to patient ______________________

Birthdate ______________ SSN# ______________ Date employed ______________

Employer ______________________

Insurance Company ______________________ Group # ______________

Ins.co.address ______________ City ______________ State ______ Zip ______

Additional Insurance

Do you have any additional insurance? ❑ Yes ❑ No If yes, complete the following:

Name of insured ______________________

Relationship to patient ______________________

Birthdate ______________ SSN# ______________ Date employed ______________

Employer ______________________

Insurance Company ______________________ Group # ______________

Ins.co.address ______________ City ______________ State ______ Zip ______

(over)

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

______________________________ Signature of patient or parent/guardian if minor

______________________________ Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively. If you have any questions at any time, please ask us. We are always happy to help.

Medical History

It is very important that I know your medical and dental history. An accurate and current history is essential to provide you with the safest, most appropriate treatment indicated for your specific situation. If there are any questions which you do not understand, just circle the question and the doctor will clarify that item at the exam. This information is strictly confidential and will not be released unless your consent is given in writing. Thank you for taking the time to completely and accurately answer this questionnaire.

Your estimated current physical health is: ❑Good ❑Fair ❑Poor Are you currently under the care of any physician? ❑Yes ❑No

Physician's name: ______________________ City/State: ______________ Phone No.: ______________

When did you last consult a physician? ______________________ Reason: ______________________

Have you been a patient in a hospital in the past 6 years? ❑Yes ❑No Reason: ______________________

Have you ever had any serious illness or operations? ❑Yes ❑No Describe: ______________________

____

Are you taking any medications, or pills either prescription or over-the-counter? Please list, ______________________

____

Do you have, or have you had any of the following?

1. Hip Replacement, Artificial Joints .... ❑Yes ❑No
   a. If yes, Location: ____________ Type: ____________
   b. How long after transplant: ______________________
   c. Any problems associated with the joint.......... ❑Yes ❑No
   Ex.: replacement, infections, hematoma
2. Immunosuppressed by either a drug or a disease.. ❑Yes ❑No
   Ex.: Systemic Lupus, Chemotherapy, Aplastic Anemia, HIV
3. Heart Disease
   a. Need to be pre-medicated with antibiotics before dental treatment .... ❑Yes ❑No
   Reason: ______________________
   b. Artificial Valve Replacement .... ❑Yes ❑No
   c. History of Bacterial Endocarditis .... ❑Yes ❑No
   d. Congenital Heart Disease.......... ❑Yes ❑No
   Ex.:
   - unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
   - a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
   - any repaired congenital heart defect with residual defect at the site adjacent to the site of a prosthetic patch or a prosthetic device.

   e. Cardiac transplant that develops a problem in a heart valve.......... ❑Yes ❑No
   f. High Blood Pressure.......... ❑Yes ❑No
   g. Myocardial Infarction, Heart Attack .... ❑Yes ❑No
   h. Pacemaker, Heart Surgery.......... ❑Yes ❑No
   i. Stroke .... ❑Yes ❑No
4. Blood Disorder:
   a. Anemia, Bleeding Problem .... ❑Yes ❑No
   b. Hemophilia.......... ❑Yes ❑No
   c. Blood Transfusion .... ❑Yes ❑No
5. Arthritis.......... ❑Yes ❑No
6. Seizures, Epilepsy, Fainting .... ❑Yes ❑No
7. Tumor History, Cancer .... ❑Yes ❑No
8. Chemotherapy, Radiation Treatment.......... ❑Yes ❑No
9. Sinus Trouble/Infections .... ❑Yes ❑No
10. Psychiatric Treatment .... ❑Yes ❑No
11. Glaucoma/Cataracts/Loss of Sight .... ❑Yes ❑No
12. Earaches, Ringing in Ears, Loss of Hearing.......... ❑Yes ❑No
13. Osteoporosis/Osteopenia
    a. Have you ever taken oral bisphosphonate such as (Actonel, Fosamax, Boniva, Shield, Dedronel, Prolia) .. ❑Yes ❑No
14. Have you ever taken IV bisphosphonate such as (Zometa, Reclast, Aredia).......... ❑Yes ❑No
15. Thyroid Disease: (Hypothyroid, Hyperthyroid) .. ❑Yes ❑No
16. Diabetes, If yes, date diagnosed ____________ ❑Yes ❑No
17. Kidney Disease .... ❑Yes ❑No
18. Ulcers.......... ❑Yes ❑No
19. Hepatitis, Liver Disease, Jaundice .... ❑Yes ❑No
20. Venereal Disease, Syphilis, Gonorrhea, Herpes. ❑Yes ❑No
21. HIV+, A.R.C., A.I.D.S.......... ❑Yes ❑No
22. Asthma, Emphysema, Bronchitis .... ❑Yes ❑No
23. Tuberculosis.......... ❑Yes ❑No
24. Chemical Dependency, Alcohol, Drug use.......... ❑Yes ❑No
25. Cigarette, Snuff.......... ❑Yes ❑No
    a. Duration ____________ Quantity ____________

24. Have you taken within the last 12 months:
    a. Cortisone, Steroids .... ❑Yes ❑No
    b. Anticoagulants, Blood Thinners .... ❑Yes ❑No

25. Allergies (Please circle)
    a. Penicillin, Erythromycin, Cephalosporins.......... ❑Yes ❑No
    b. Tetracycline .... ❑Yes ❑No
    c. Other Antibiotics .... ❑Yes ❑No
    d. Codeine .... ❑Yes ❑No
    e. Aspirin .... ❑Yes ❑No
    f. Sleeping Pills .... ❑Yes ❑No
    g. Dental Anesthetics.......... ❑Yes ❑No
    h. Other .... ❑Yes ❑No

Women

1. Regular Menstrual Cycle.......... ❑Yes ❑No
2. Are You Pregnant.......... ❑Yes ❑No
3. Are You Taking Birth Control Medication.......... ❑Yes ❑No
4. Are You Taking Hormone Supplements.......... ❑Yes ❑No

(Continued on back)

Dental History

Present Dental Complaint? ____

____

Have you experienced any unfavorable reaction to previous dental treatment? Describe ____

____

Who is your regular dentist? ______________________ For how long? ______________

When did you last have any dental work? ______________________ What was done? ______________

When were your teeth last cleaned? ______________________ How long before that? ______________

How often do you brush your teeth? ______________________ Floss? ______________

Are you using any other dental cleaning aids? If so, what? ____

- Are you experiencing any pain in your mouth. Where? ______________________ ❑ Yes ❑ No
- Are your teeth sensitive........................ ❑ Yes ❑ No
- Are any of your teeth loose........................ ❑ Yes ❑ No
- Do you have any unpleasant taste or odor in your mouth........................ ❑ Yes ❑ No
- Do your gums bleed? If yes, when? ______________________ ❑ Yes ❑ No
- Do you grind or clench your teeth........................ ❑ Yes ❑ No
- Have you noticed increasing spaces between teeth? If yes, when? ______________________ ❑ Yes ❑ No
- Are your gums receding........................ ❑ Yes ❑ No
- Are you missing teeth? Reasons: Cavities ( ) Gum Disease ( ) Trauma ( )........................ ❑ Yes ❑ No
- Were missing teeth replaced........................ ❑ Yes ❑ No
- Are you satisfied with the appearance of your teeth........................ ❑ Yes ❑ No
- Has periodontal disease been found in your mouth before? If yes, when? ______________________ ❑ Yes ❑ No
- Have you ever had periodontal treatment? If yes, when? ______________________ ❑ Yes ❑ No
- Have you ever had orthodontic treatment (braces)........................ ❑ Yes ❑ No
- Are you seeing a doctor for DENTAL IMPLANTS........................ ❑ Yes ❑ No
- Do you presently wear full dentures? Upper ( ) Lower ( )........................ ❑ Yes ❑ No
- Do you presently wear removable partial dentures? Upper ( ) Lower ( )........................ ❑ Yes ❑ No
- Are you interested in replacing your denture or partial with implants........................ ❑ Yes ❑ No
- Why are you dissatisfied with your present appliances:

  ____ The inconvenience ____ The appearance ____ Inability to chew ____ Painful ____ Other
- Do you presently have missing teeth that have not been replaced........................ ❑ Yes ❑ No

Treatment Authorization and Informed Consent

I consent to examination as necessary or desirable to care of the registered patient, for the diagnosis of dental disease, deformity, or treatment or dental emergency. The procedures may include radiographs, models, photographs and intra-oral exam. In case of a dental emergency, I consent to emergency treatment as deemed necessary by the doctor, understanding that procedures will be explained in advance. I have read and completed this questionnaire to the best of my knowledge and agree to the above policy.

______________________________ ______________________________

Patient, Parent or Legal Guardian Date Periodontist Date

FLAGSTAFF PERIODONTICS, P.C.

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 APRIL 14, 2003, 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 may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: DR. PONTIP BAILLIE

Telephone: 928-779-3644 Fax: 928-773-9872

E-mail: FLAGSTAFFPERIODONTICS@YAHOO.COM

Address: 1600 W. UNIVERSITY STE 107 FLAGSTAFF, AZ 86001

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

FLAGSTAFF PERIODONTICS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, ____ have received a copy of this office's Notice of Privacy Practices.

____

Please print name

____

Signature

____

Date

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

____

____

____

Flagstaff Periodontics, P.C.
Limited to Periodontics and Implant
Brandon Baillie, D.D.S.
Pontip Baillie, D.D.S., M.S.
1600 W. University, Ste. 107
Flagstaff, Arizona 86001
(928) 779-3644

My staff and I wish to welcome you to our practice. Thank you for selecting us for your periodontal care. ***Please read this letter as it describes our operating procedures.***

Our office is committed to the control and prevention of periodontal disease. It is our belief that with specialized treatment and the proper care at home, patients can retain most of their natural teeth for a lifetime. It is our goal to provide you with the best and most advanced periodontal care possible and to do so in a comfortable, gentle and supportive manner. With your cooperation this can be achieved.

At your first appointment, you will receive a periodontal examination directed toward your specific condition or treatment need. This examination may include radiographs, which will assist Dr. Baillie in the establishment of your diagnosis and treatment plan. Your teeth will typically not be cleaned on the same day that you are examined.

Alternately, we do consider our patients responsible for arriving to their scheduled appointments. We will place a courtesy call to our patients two to three days prior to their appointment. When appointments are cancelled with less than 48 hours notice, our office may assess a non-refundable fee of $50.00, which must be paid prior to re-scheduling.

Enclosed you will find a patient registration dental/medical history form and our financial policy. Please read this information, fill out all required information, sign and bring with you to your appointment. If you have dental insurance please bring your insurance card with you. We will be able to serve you more efficiently if you have all of your personal information filled out prior to your appointment. Please do not hesitate to call if you have any questions regarding this information.

Once again, we want you to know that if at any time you have questions or concerns regarding treatment, fees or services, please discuss them with us. We sincerely appreciate you selecting our practice and look forward to meeting you soon.

Sincerely,

Brandon Baillie, D.D.S
Pontip Baillie, D.D.S., M.S.
and Staff

Flagstaff Periodontics, P.C.
Limited to Periodontics and Implants
Brandon Baillie, D.D.S.
Pontip Baillie, D.D.S., M.S.
1600 W. University Ste 107
Flagstaff, Arizona 86001
(928) 779-3644

FINANCIAL AGREEMENT

Patient's Name: ______________________________

Responsible Party (if not patient): ______________________________

Signature: ______________________________ Date: ____________

Co-Signature (if required): ______________________________ Date: ____________

In order that we may continue to provide you with the finest quality and highest standard of care, we must request full payment be received at the time professional services are rendered. As a convenience for you, we offer a number of payment options.
Please read carefully and select the payment options most suitable for your individual situation. By executing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have NO dental insurance:

1. You choose to pay by ____ cash, ____ check, ____ credit card (Visa/MasterCard/Discover or American Express) or ____ CareCredit (6 months 0% interest, or 24, 36, 48, 60 months extended pay plan at 14.9% interest) on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure a bank, credit union, or third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have Delta Dental insurance:

1. We will do our best to help you utilize your benefits. If your insurance company becomes uncooperative, or refuses to settle your claim in a timely manner (30 days following treatment and/or following the submission of first appeal), our office maintains the right to bill both the patient and insurance company in question for interest on any outstanding balance. If such a situation arises, the patient is responsible to settle any dispute as the insurance provider is not responsible to our office, but to you the policyholder.
2. **For Delta insurance**, you are to pay the estimated patient portion of the procedure cost on the day services are provided. You may choose to pay by ____ cash, ____ check, ____ credit card or ____ CareCredit.
3. **For all other insurances**, we require full payment on the day the treatment rendered. As a courtesy to you, we will send the dental claims to your insurance. Your insurance will then send their payment to you directly. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. Please be aware that some and perhaps all of the periodontal services you receive may be non-covered services and may arbitrarily not be considered "reasonable and necessary" under the dental insurance plan. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This process may take from 4-6 weeks depending on your insurance company. Failure to obtain the referral and/or preauthorization may result in a lower payment from your insurance company.
    a. You choose to pay by ____ cash, ____ check, ____ credit card (Visa/MasterCard/Discover or American Express) or ____ CareCredit (6 months 0% interest, or 24, 36, 48, 60 months extended pay plan at 14.9% interest) on the day that treatment is rendered.
    b. On extensive treatment, you may prefer to secure a bank, credit union, or third-party financing for the entire amount and make payments to the lending institution.

Notice to Insurance Patients: You are responsible for your balance if any of the following occurs:

1. The treatment provided exceeds my yearly maximum benefit.
2. Any treatment is denied by my insurance company.
3. I am not eligible for insurance.
4. I prevent or delay payment by not complying with requests for insurance forms or signatures.
5. I do not complete my treatment and insurance denies payment as a result.
6. Our practice is committed to providing the best treatment possible for our patients and our charges are in fact the usual and customary rates for our area. You are responsible for the payment in full regardless of any insurance company's arbitrary determination of their usual and customary rates, except Delta Insurance.
7. If treatment is not a covered benefit.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which incur plus all court costs. In case of suit, you agree venue shall be in Coconino County, Arizona.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Missed Appointments: Patients with three missed appointments will be asked to transfer their records to another doctor.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency, such as a credit bureau.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee of $25.00, if you request to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.