New Patient Pre-Appointment Check-List

Welcome to our practice.We want to make sure your first visit to our office is an exceptional one. To help us meet your expectations please use this check-list to make sure we have all of the information we will need for your visit.

- ❑ Contact your previous dentist and ask them to send your records to:
  bcfamilydentistry@gmail.com
- ❑ Complete new patient forms before you arrive and bring them with you to your appointment. You can complete the forms electronically but please print them out and bring them with you.
- ❑ Arrive 10 minutes before scheduled time for paperwork
- ❑ Bring your insurance card
- ❑ Bring your driver's license or other government issued photo ID
- ❑ If you are a dependent on an insurance plan please have:

  Insured's Name,Address, and Phone Number
  Insured's Date of Birth
  Insured's Member ID# or SSN
  Insurance Group Number
  Insured's Employer
- ❑ Have a list of all medications you are currently taking
- ❑ Take any pre-medications required by your physician

We look forward to meeting you!

Dr. Browning, Dr. Koo, and Team

365 S Linden Ave | Waynesboro, VA 22980 | 540.943.4215 | bcfamilydentistry@gmail.com

About You

Patient Name ______________________________

What do you prefer to be called ________________

Address ________________________________

City ____________________ST ___Zip ________

Home Phone ____________________________

Cell Phone _____________________________

Work Phone ____________________________

Email _________________________________

Birthdate ________________ ☐Male ☐Female

☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Social Security Number ____________________

Please check all the ways you heard about our office

☐ Friend/Family ☐ Internet ☐ Facebook

☐ Insurance ☐ Print Ad ☐ Our Staff

If a friend or family member referred you, we would like to thank them. To whom may we send our thanks?

____

Employer ________________________________

Occupation ______________________________

Spouse/Partner Name _______________________

Please check the best way to remind you of your dental appointments

Text message Email message

Responsible Party

Person Responsible for this Account ____________

Address ________________________________

City ____________________ST ___Zip ________

Relationship to Patient _____________________

Employer ________________________________

Payment in full is required at each appointment. For your convenience we offer the following methods of payment. I prefer to pay via:

☐ Cash ☐Check ☐Visa ☐MC ☐Disc

I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand that I am responsible for all charges to my account regardless of the decision of my insurance company to pay or deny benefits for any reason. I also understand that a fee for missed appointments with less than 2 business days notice will be assessed to my account. No appointments will be made until this fee is paid.

_________________________________Date________

Signature of Patient/Parent if Under 18/Guardian

BROWNING
Family Dentistry

365 S Linden Ave | Waynesboro, VA 22980 | 540.943.4215 | bcfamilydentistry@gmail.com

Dental Insurance Information

Primary Insurance:

Insured's Name ______________________________

Relationship to Patient _______________________

Birthdate ________________ ☐ Male ☐Female

Employer ___________________________________

Work Phone _________________________________

Insurance Carrier _____________________________

Ins. Co. Address ______________________________

City ____________________ST____Zip__________

Policy/ID # _________________________________

Subscribers SSN # ____________________________

Group #____________________________________

Deductible $ _________ Annual Maximum $ ________

In Case of Emergency

Whom should we contact? _______________________

Relation ____________________________________

Home Phone _________________________________

Cell Phone __________________________________

Work Phone _________________________________

Patient Name ______________________

Medications

During the past year have you taken any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants (e.g. Coumadin)
- ☐ Drugs for heart problems
- ☐ Nitroglycerin
- ☐ Birth Control Pills
- ☐ Vitamins
- ☐ Biophosphonate (e.g. Fosamax)
- ☐ High blood pressure meds
- ☐ Sulfa drugs
- ☐ Tranquilizers
- ☐ Insulin
- ☐ Cortisone
- ☐ Diet Pills
- ☐ Herbal Supplements
- ☐ Blood Thinners

Other Medications-Please List: ______________________

____

____

List Any Allergies to Medications______________________

____

____

ARE YOU ALLERGIC TO LATEX? ☐ **Yes** ☐ **No**

Medical History

Are you under the care of a physician now? ☐ Yes ☐ No

Have you ever been hospitalized? ☐Yes ☐ No

Reason?______________________

Women, are you pregnant? ☐ **Yes** ☐**No**

Have you ever, or do you now use controlled substances? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Please check if you have, or have had any of the following medical conditions:

- ☐ Congenital Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve/Stent
- ☐ Stents
- ☐ Stroke
- ☐ Chest Pain
- ☐ Angina
- ☐ Chemo or Radiation
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Excessive Thirst/Dryness
- ☐ Frequent Diarrhea
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Multiple Sclerosis
- ☐ Stomach/Intestinal
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Transplant
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Cancer of any Kind
- ☐ Artificial Joints
- ☐ Shortness of Breath
- ☐ Blood Disease
- ☐ Epilepsy or Seizures
- ☐ Frequent Cough
- ☐ Fainting/Dizziness
- ☐ Herpes
- ☐ HIV/Aids
- ☐ Hypoglycemia
- ☐ Leukemia
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Multiple Dystrophy
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Glaucoma

Other Medical Conditions Not Listed:

____

____

Dental History

When was your last dental cleaning? ______________________

How often do you have your teeth cleaned? ______________________

Are you experiencing dental pain now? ☐Yes ☐ No

If so, where? ☐ Upper Left ☐ Upper Front ☐ Upper Right ☐ Lower Left ☐ Lower Front ☐ Lower Right

Is the pain associated with?

☐Biting ☐ Sweets ☐ Cold ☐Heat ☐ Air

Are you taking any medications for this pain? ☐ Yes ☐ No

Are you apprehensive about dental treatment? ☐ Yes ☐ No

Does food become lodged between teeth? ☐ Yes ☐ No

Do you have difficulty chewing your food? ☐ Yes ☐ No

Do you avoid chewing due to pain? ☐ Yes ☐ No

Do you avoid brushing or flossing due to pain? ☐ Yes ☐ No

Does your breath concern you? ☐ Yes ☐ No

Have you ever been diagnosed with periodontitis or peridontal disease? ☐ Yes ☐ No

Have you ever noticed slow healing sores in your mouth? ☐Yes ☐ No

Do you smoke or chew tobacco? ☐Yes ☐ No

Do you brush your teeth at least twice a day? ☐ Yes ☐ No

Do you floss at least once a day? ☐Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No

Does your jaw hurt when you chew or open it wide to take a bite? ☐ Yes ☐ No

Has any medical doctor advised you to take a pre-medication prior to dental care? ☐ Yes ☐ No

Do you wear any type of retainer, night-guard or removable oral appliance? ☐ Yes ☐ No

If yes, please describe______________________

What would you change about your smile? ______________________

____

What did you like about your previous dentist?______________________

____

What did you dislike about your previous dentist?______________________

____

Are you interested in discussing braces? ☐Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

Previous Dentist ______________________

Telephone # ______________________

Medical Doctor ______________________

Telephone # ______________________

I understand that the information I have provided on these forms is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be necessary, you have my permission to request that information from the respective health care provider and for them to release to you. I will notify the doctor of any change in my health or medications.

______________________Date______________

Signature of Patient/Parent if Under 18/Guardian

____

Printed Name

Financial Policies and Acknowledgments

365 S Linden Ave | Waynesboro, VA 22980 |
540.943.4215 | bcfamilydentistry@gmail.com

We believe that all patients deserve to know, up front, our financial policies. Below are our policies relating to your dental carW

Payments at the time of service:

At the time of service, your estimated co-payment is due. For procedures with multiple appointments, at least fifty percent of your estimated portion is due at the first appointment and the balance is due by the beginning of the final appointment.

Dental Insurance:

As a courtesy we will file your insurance claim for you. We offer this service to you as a courtesy only and it is not meant to substitute for payment. We will attempt to collect from your insurance carrier their portion of the charges for your visit. We can not guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure. It is your responsibility to know your dental coverage. It is your responsibility to pay any amount not covered by your insurance company regardless of the reason. We will instruct your insurance carrier to send all payments directly to our office for reimbursement.

Pre-Determination of Insurance Benefits:

We will file, upon your request, a request for pre-determination of dental benefits from your insurance carrier. A pre-determination is a process whereby your insurance company tells you in advance of treatment what procedures may be covered and the amount of benefits your plan may pay towards those procedures and the amount you may be required to pay. A pre-determination of benefits reduces, but does not eliminate the risk of error in estimating your co-payment. A pre-determination is not a guarantee of coverage. A
pre-determination sets forth your expected benefits based on the information provided to the carrier at the time of processing. your plan changes, additional claims are received after the pre-determination is processed or your oral condition changes then the pre-determination is not valid and may need to be resubmitted. Depending on your insurance carrier, a pre-determination may take up to
six weeks to process.

Third-Party Financing:

Browning Family Dentistry offers financing options through various third-party lenders. Arrangements for these options must be made in advance of your appointment.

______ *(Initial)*

Interest Charges:

Patient balances sixty (60days and older will be assessed an interest charge of 1.5% per month, or 18% per annum with a minimum charge of $5.00 per billing period.

______ *(Initial)*

Collection Charge and Returned Checks:

Any account sent to an outside collection agency will be assessed a $50 collection fee. Any check returned for any reason by your bank will be assessed a $35 fee.

______ *(Initial)*

Missed/Cancelled Appointment Charge:

Any appointment that is missed or not cancelled within 2 business days (our business days are Monday through Thursday of the appointment will be subject to a charge of $75.00 for first occurrence. Future missed or cancelled appointments may require a deposit prior to rescheduling in addition to the missed or cancel fee. No further appointments will be made until the fee is paid. Cancellations must be made during business hours. Messages left after 5pm will be considered to have been made on the next business day.

I have read, understood and agreed to all of the above Financial Policies of Browning Family Dentistry. I understand that treatment cannot begin until this form is signed and agreed to.

Signature of Patient/Parent if Under 18/Guardian

______________________________ Date ______________

Printed Name

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse To Sign This Acknowledgement**

I have received a copy of Browning Family Dentistry'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 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)

Browning Family Dentistry
365 S Linden Ave
Waynesboro, VA 22980
540.943.4215
bcfamilydentistry@gmail.com

NOTICE OF PRIVACY PRACTICES
Browning Family Dentistry

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, 2014, 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. Health-care 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 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 voice-mail 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

Restrictions: 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: Courtney Britt
365 S Linden Ave
Waynesboro, VA 22980
540.943.4215
540.949.6519
bcfamilydentistry@gmail.com