Alvis Burris D.M.D

Cosmetic & Family Dentistry

Welcome to our practice! We are genuinely pleased that you have chosen us for your dental care. Our practice realizes the importance of referrals and we value them greatly. We are always excited to see new smiles coming through our door.

At your first appointment, your doctor will complete a comprehensive oral examinations. This includes a complete review of your medical and dental history, all necessary x-rays and intraoral photos, oral cancer screening, periodontal health evaluation, and examination of your teeth. Staff members will assist in completing your oral health evaluation following the exam, the doctor will discuss their finding with you, and develop a treatment plan and financial plan that is right for you. Patients of record are required to keep their 3 ,4 or 6 month preventative appointments the doctor will decide this at your initial visit.

Enclosed you will find a health history form, and information on locating our office. Please complete the enclosed forms and bring them with you to your first appointment. If you have dental insurance, please bring your insurance card and identification.

Payment is expected at time of service. If you are covered by insurance, we will expect payment of your portion at this time. As a courtesy we will file your claims on your behalf with the dental insurance company. If you would like to finance your dental expenses we work with Care Credit and Springstone and we will be glad to provide you with information and how to apply. If you have any questions about finances please feel free to ask us at any time.

We ask that you make every effort to keep your appointments. If you need to reschedule your appointment Please call us at least 24 hours prior to your visit.

We very much appreciate your confidence in us and look forward to meeting with you!

Sincerely,

The Dental Team at Burris Cosmetic and Family Dentistry

Cosmetic & Family Dentistry

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in you health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: ____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email: _____

SS#: _____ Employer/Occupation: _____ Bus. Phone: _____

Spouse's name & phone: _____ Emergency phone# (other than spouse) _____

Primary dental insurance: _____ Group #: _____

Secondary dental insurance: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____ SS #: _____

Name of medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush?		
How often do you floss?		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, anti-depressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

Medical History

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.

Are you under a physician's care now?	☐ Yes ☐ No	If yes _____
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes _____
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes _____
Are you taking any medication, pills, or drugs?	☐ Yes ☐ No	If yes _____
Do you take or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?	☐ Yes ☐ No	If yes _____
Are you on a special diet?	☐ Yes ☐ No	**Any additional medications:** _____
Do you use tobacco?	☐ Yes ☐ No	_____
		_____

Women: Are You...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are You allergic to any of the Following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic	☐ Gluten
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Pine Nuts

Other allergies? ☐ Yes ☐ No If yes _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

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

AIDS/HIV Positive ☐ Yes ☐ No	Cortisone Medicine ☐ Yes ☐ No	Hepatitus A ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No
Alcohol Addiction ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Hepatitus B or C ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alzheimer's Disease ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Easily Winded ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Shingles ☐ Yes ☐ No
Angina ☐ Yes ☐ No	Epilepsy or Seizures ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Arthritis/Gout ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Artificial Heart Valve ☐ Yes ☐ No	Excessive Thirst ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Spina Bifida ☐ Yes ☐ No
Artificial Joint ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Kidney Problems ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Frequent Cough ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No	Frequent Diarrhea ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Swelling of Limbs ☐ Yes ☐ No
Blood Transfusion ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Low Blood Pressure ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Genital Herpes ☐ Yes ☐ No	Lung Disease ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Bruise Easily ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mental Illness ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Hay Fever ☐ Yes ☐ No	Mitral Valve Prolapse ☐ Yes ☐ No	Tumors or Growth ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Chest Pains ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No
Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Parathyroid Disease ☐ Yes ☐ No	Yellow Jaundice ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Trouble/Disease ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	
Convulsions ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Recent Weight Loss ☐ Yes ☐ No	

Have you ever had any serious illness not listed? ☐ Yes ☐ No If yes _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or 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 payments of all services rendered on my behalf or my dependants.

_____

Signature of patient (or parent/guardian if minor) *Date*

Doctor's Comments _____

_____

_____ *Signature* _____ *Date* _____

Alvis Burris D.M.D.

Cosmetic & Family

Dentistry

In order to diagnose at the highest possible level, it's important to have radiographs (x-rays) at your first visit. Radiographs, as long as they are legible can be brought from another dental office for us to view.

If radiographs are not brought to your visit, it is our office policy to take them to do a comprehensive exam. This fee is charged whether your insurance company will or will not cover them.

Good diagnosis in most cases will help us in preventing more expensive dental care. Please understand that the rational for this is based on the principle of providing quality dental care experience with the lowest cost, best diagnosis, all while safely caring for you/and or your family.

By signing this I am acknowledging that I have read and understand this office radiograph (x-rays) policy.

Date_____

Patient Signature_____

A033C081 **FINANCIAL AGREEMENT**

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all our patients. Please review the following policies and procedure:

PAYMENT POLICY: PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If you have dental insurance, your estimated co-pay plus deductible is due at the time of services. If no insurance is involved, payment is expected at each visit.

1.) We accept cash, personal checks with proper ID, money orders, Debit cards, Visa, MasterCard, Discover.
2.) If there is a balance and the charges have been on the account for over, you 30 days will pay Burris Cosmetic and family dentistry LLC **2%** finance charge per month on the unpaid balance until paid in full.
3.) You will be responsible for any costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/or attorney fees.
4.) Financing available through Care Credit with prior approval.
5.) Fee will apply for any checks that is returned by the bank .
6.) MINOR PATIENTS: In case of divorced or separated parents, it is **YOUR** responsibility to have financial arrangements made according to the divorce decree before treatment begins.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental benefits provided you agree to the following:

1.) You must provide us with an insurance card and /or all of the information necessary to verify your coverage and file your claim.
2.) Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you:
3.) You are responsible to pay our fees; not what your insurance company allows or considers “usual, customary and reasonable” (UCR), all of which may vary from one company to another.
4.) Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefits amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
5.) All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.
6.) Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance if this applies to you.
7.) There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what you’re out of pocket expense will be.
8.) Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of $45.00.Missed or broken appointments prevent others from receiving the dental care they deserve.

I have read and understand this document in its entirely; outlining the office and the financial policies of Burris cosmetic and family dentistry LLC and agree to these terms.

Signature of patient or parent/guardian_____ Date_____

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 this healthcare facility. 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 / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

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

☐ First Name Only ☐ Proper Sir Name ☐ 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