The Bonner Dental Network, PC
Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell) _____

EMAIL Address_____ Emergency Contact _____ PH# _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please circle yes or no:

AIDS/HIV Y/N
Drug Allergies:
_____
_____
Anemia Y/N
Arthritis Y/N
Artificial Joints Y/N
Asthma Y/N
Blood Disease/Hemophilia Y/N
Cancer Y/N
Diabetes Y/N
Dizziness Y/N
Epilepsy Y/N
Excessive Bleeding Y/N
Fainting Y/N
Glaucoma Y/N
Growths Y/N

Hay Fever Y/N
Head Injuries Y/N
Heart Disease Y/N
Heart Murmur Y/N
Hepatitis Y/N
High Blood Pressure Y/N
Jaundice Y/N
Kidney Disease Y/N
Latex Allergy Y/N
Liver Disease Y/N
Mental Disorders Y/N
Mitral Valve Prolapse Y/N
Nervous Disorders Y/N
Pacemaker Y/N
Pregnant Y/N
Due date:_____

Radiation Treatment Y/N
Respiratory Problems Y/N
Rheumatic Fever Y/N
Rheumatism Y/N
Sinus Problems Y/N
Stomach Problems Y/N
Stroke Y/N
Tuberculosis Y/N
Tumors Y/N
Ulcers Y/N
Venereal Disease Y/N
OTHER:
☐ List Prescribed medications taken_____
_____
_____

☐ BP____/_____
☐ RESP_____
☐ PULSE_____

**********DO YOU WANT WHITENING? YES/NO **********

ON A SCALE OF 1-10, 10 BEING THE HIGHEST RATING
How important is your overall smile to you? **1 2 3 4 5 6 7 8 9 10**
Do you like your smile? **YES/NO**
Do you have missing teeth **YES/NO** Do you cover your mouth when you smile? **YES/NO** Do you like to smile when you take pictures? **YES/NO**
Do you think that having a perfect smile would improve your life? **YES/NO** Would you like Straighter Teeth? **YES/NO**
What is the most important thing to you about your smile and dental health? _____
What is the most important thing to you about your dental visit today? _____

1. Do your gums bleed while brushing or flossing? **YES/NO**
2. Are your teeth sensitive to hot or cold liquids/foods? **YES/NO**
3. Are your teeth sensitive to sweet or sour liquids/foods? **YES/NO**
4. Do you feel pain to any of your teeth? **YES/NO**
5. Do you have any sores or lumps in or near your mouth? **YES/NO**
6. Have you had any head, neck or jaw injuries? **YES/NO** Difficulty in opening or closing? **YES/NO**
7. Do you clinch/grind your teeth? **YES/NO** Do you hear clicking when you open and close? **YES/NO**
8. Have you ever had prolonged bleeding following extractions? **YES/NO**
9. Do you bite your lips or cheeks frequently? **YES/NO**

- Is there anything you wish to improve about your smile? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Please provide following information for emergency purposes only
- Physician or Medical facility: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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, I will inform the doctors at the next appointment without fail.

_____ Date: _____ Reviewed by: _____ Date: _____

General Consent for Treatment

I hereby consent to the performance of dental treatment upon_____ by The Bonner Dental Network, PC.
Patient Name

Such treatment will be explained to me and will not proceed without my acceptance. I reserve the right to ask specific questions before recommended treatment commences.

The nature and purpose of the treatment rendered, possible hazards, and alternative methods of treatment will be fully explained to me. I understand the risks involved with proceeding with treatment. No guarantee, warranty, or assurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of The Bonner Dental Network, PC. I understand that there is a 25% down payment for all scheduled treatment other than preventive care which is collected either in person or over the telephone.

_____ Date_____
Signature of Patient or Legal Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

The Bonner Dental Network, PC
Spouse or Responsible Party Information

The following is for: Individual responsible for non reimbursed insurance cost.

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Financial Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance, to expedite processing time, we will work with your insurance company to ensure that our services are billed properly, and that all necessary information is submitted with claims. Most insurance carriers are required to pay physicians within 30 days: however, the ultimate responsibility for timely payment of services lies with the patient. After 30 days, any outstanding account balance due to unpaid insurance claims will become your responsibility, and payment will be expected upon receipt of a statement.
Patients with secondary insurance, we will assist in collecting reimbursement for said services for an additional 30 days. We proceed with collections for any unpaid balance overdue by at least 90 days.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.
I also understand that Insurance estimates and Please Pay amounts are based on said insurer and are provided as a courtesy. In the event that your insurance carrier pays less than the estimated amounts, you are responsible for the unpaid balance. Contact your Human Resources Department and / or Insurance Carrier to get more details about your specific plans so you can understand your financial responsibility.

Please contact our Financial Manager to discuss your treatment plan and the payment options available to make it easy and convenient for you.

THERE IS BROKEN APPOINTMENT FEE FOR ALL APPOINTMENTS CANCELLED WITHIN 48 BUSINESS HOURS AS WELL AS NO SHOWS.

_____ Date: _____
Signature of patient, parent or guardian

HIPAA PRIVACY FORM

Consent for Use and Disclosure of Health Information

Info is for interacting with your insurance carrier as well as referrals to specialists only

Purpose: In cases where **Dr. Leslie Bonner** has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

The Bonner Dental Network

1147 20th St. NW Suite B1

Washington, DC 20036

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____ Birth date _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Bonner
Office Phone: 202.249.9131 Fax: 202.249.2851
E-mail: **thebonnerdentalnetwork@gmail.com**
Address: 1147 20th St. NW Suite B1
Washington, DC 20036

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Financial Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

(please read CAREFULLY)

Using dental insurance? Yes _____ No _____

All co-pays, deductibles and non-covered procedures are the patient's responsibility and must be paid at the time the services are rendered.

We will assist you with filing claims and obtaining the maximum benefits available under the terms of your policy. However please be aware that certain procedures and services may not be covered as dental insurance is designed to reduce your cost but not to eliminate the cost. Also please understand that your insurance is a contract between you and insurance company; therefore it is your responsibility to learn about your policy's coverage and exclusions. It is also your responsibility to make sure that we are IN-NETWORK with your specific plan and to provide us with the correct and current insurance information at least two (2) days before your appointment. If you fail to so, then you agree to be responsible for 100% of our standard office fees for that visit.

To expedite processing time, we will work with your insurance company to ensure that our services are billed properly and that all necessary information is submitted with the claims. Most insurance carriers are required to pay the physician with-in 30 days: however, the ultimate responsibility for timely payment of service lies with the patient. After the 30 days, any outstanding account balance due to unpaid insurance claims will become your responsibility and payment will be expected upon receipt statement.
Patients with secondary insurance; we will assist in collecting reimbursement for said service for an additional 30days. We proceed with collections for any unpaid balance overdue by at least 45 days via Transworld.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I also understand that dental treatment will not be finalized unless all payments have been made, barring established, signed payment arrangements.

Payment for services performed: We accept MasterCard, Visa, American Express, Discover and each cash for payment of services. Established patients may also use personal checks. Additionally, we offer assistance applying for dental financing, some of which can be interest-free depending on the cost of treatment and type of payment plan selected.

Return checks and Overdue account balances: There will be a $50.00 fee for returned checking and $100.00 for cancelled checks. A warrant- in – debt will be filed with the District of Columbia federal Court for any retuned check not re-paid with-in five (5) business days. Any account balances exceeding 30 days will incur a late fee at the rate of 1.5% every month until balance is paid in full.
You will be responsible for all collection fees, attorney's fees and court costs.

Obtaining copies of your dental records: In accordance with the District of Columbia and HIPPA regulation (45 C.F.R § 164.524) our office is required to maintain all original X-ray films, however copies of x-rays films can be made with a duplication fee of $50.00 per set (this fee is waived as a curiosity the first time). A copy of the chart records (excluding X-rays) can be made with a duplication fee of $20.00 per person. You must submit a written consent form (which may be emailed) for the release of all records and allow up to 48-72 hours for processing. X-rays will be placed on a CD and you have the option to pick them up or have them mailed to you or the dental office of your choice.

Assignment of Insurance Benefits: I, _____, hereby authorize direct payment of dental benefits to the office of Dr. Leslie Bonner for services rendered by them or in person or under their supervision.
I understand I am financially responsible for any balance not covered by my insurance.

Authorization: I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. I also understand that Insurance estimates and please pay amounts are based on said insurer and are provided as a courtesy. In the event that your insurance carrier pays less than the estimated amounts, you are responsible for the unpaid balance. Contact your Human Resources Department and / or Insurance Carrier to get more details about your specific plans so you can understand your financial responsibility. Please contact our Financial Manager to discuss your treatment plan and the payment options available to make it easy and convenient for you.

THERE IS A FEE OF $50 (MINIMUM) FOR ALL APPOINTMENTS BROKEN OR CANCELLED WITH LESS THAN 48 BUSINESS HOURS NOTICE.

_____ Date: _____
Signature of patient, parent or guardian

09/14/2017