Bella Vista Dental, LLC

Dr. John A. Kennedy Jr., DMD

Thank you for choosing Bella Vista Dental to be your *Dental Home*. We consider this a privilege and honor to allow us to care for your dental needs. Our staff is committed to serve you in the most professional manner. To insure that your health is safe guarded to the utmost, we ask that you complete the following questionnaire as accurately as possible. This information is held in strict medical confidence.

PATIENT INFORMATION

Date ____ / ____ / ____

Name_____
Last First Middle

Gender ☐ Male ☐ Female

Street Address _____

Birth Date

City _____ ST _____ Zip _____

E-mail Address _____ Home Phone_____ Cell Phone or Pager _____

Employer_____ Work Phone_____

Driver's License#_____ If patient is a minor, give parent's or guardian's name_____

Emergency contact person (other than spouse):_____ Relationship _____

Address:_____ Phone number _____

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

SPOUSE INFORMATION

Spouse's Name_____
Last First Middle

Street Address_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ D.O.B. _____

Employer _____

RESPONSIBLE PARTY INFORMATION

Name _____ _____
Last First Middle Marital Status

D.O.B._____ Relationship to Patient_____

Employer_____ Work Phone_____ Occupation_____ No. Years Employed_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance _____ Secondary Dental Insurance_____

Insured Name_____ Insured Name_____

Date of Birth _____ Date of Birth _____

Insured Employer _____ Insured Employer_____

Relationship to Patient_____ Relationship to Patient_____

If there were a safe and inexpensive way to brighten your smile, would you be interested? ☐ YES ☐ NO

(PLEASE COMPLETE REVERSE SIDE)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

DENTAL HISTORY

Do you have a specific dental problem? Describe_____

Do you have dental examinations on a routine basis? Last Visit?_____

Do you ever have clicking or discomfort in the jaw joints (TMJ)? Describe_____

Name of previous dentist (optional)_____

MEDICAL HISTORY

Are you under a physician's care now? Doctor's Name? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No List Medications:_____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No **Can we help you quit smoking? ☐ Yes ☐ No**

WOMEN Are you: ☐ Pregnant/ Trying to get pregnant? ☐ Nursing? ☐ Taking Oral Contraceptives?

Are you allergic to any of the following? Do you have any allergies? Please list:_____

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Please CHECK if you have any of the following:

☐ AIDS/ HIV Positive	Chest Pain	Glaucoma	Leukemia	Sinus Trouble
Alzheimer's Disease	Cold Sores/Fever Blisters	Hay Fever	Liver Disease	Spine Bifida
☐ Anaphylaxis	Congenital Heart Disorder	Heart Attack/ Failure	Low Blood Pressure	Stomach Disease
☐ Anemia	☐ Convulsions	**Heart Murmur***	Lung Disease	Stroke
☐ Angina	☐ Cortisone Medicine	**Heart Pace Maker***	**Mitral Valve Prolapse***	☐ Swelling of Limbs
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Trouble/ Disease	☐ Pain in Jaw Joints	☐ Thyroid Disease
☐ **Artificial Heart Valve***	☐ Drug Addiction	☐ Hemophilia	☐ Parathyroid Disease	☐ Tonsillitis
☐ **Artificial Joint***	☐ Easily Winded	☐ Hepatitis A	☐ Psychiatric Care	☐ Tuberculosis
☐ Asthma	☐ Emphysema	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tumors or Growths
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Herpes	☐ Recent Weight Loss	☐ Ulcers
☐ Blood Transfusion	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Renal Dialysis	☐ Venereal Disease
☐ Breathing Problem	☐ Excessive Thrist	☐ Hives or Rash	☐ **Rheumatic Fever***	☐ Yellow Jaundice
☐ Bruise Easily	☐ Fainting	☐ Hypoglycemia	☐ Rheumatism	
☐ Cancer	☐ Spells/Dizziness	☐ Intestinal Disease	☐ Scarlet Fever	
☐ Chemotherapy	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Shingles	
	☐ Frequent Diarrhea	☐ Kidney Problems	☐ Sickle Cell Disease	
	☐ Frequent Headaches			
	☐ Genital Herpes			

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parent or Guardian Date

Dentist's Comments:					
Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date
Dentist's Signature	Date	Dentist's Signature	Date	Dentist's Signature	Date

Bella Vista Dental, LLC
Financial Policy

Thank You for chosing Bella Vista Dental to be your new *Dental Home*. We are a fee-for-service dental practice that requires payment at the time of service. For those patients who have financial assistance from dental insurance, the full co-payment is due at time of service.

We gladly accept cash, personal check or most major credit cards. We are proud to also offer CareCredit for those times when financial assistance is needed. We'll be happy to discuss any of these payment options with you.

Emergency Patients:
For emergency patients who are not patients of record, we will file any insurance claims, as long as we can verify your insurance coverage and remaining benefit level. If we are unable to verify these benefits, we will require payment in full.

Minors with two separated or divorced parents:
When two parents are each responsible for one half of the cost of the children's dental care, the parent who brings in the child is responsible for paying the full co-payment or full fee. They will also be responsible for collecting payment from the other parent.

NSF/ Returned Checks:
There is a $25.00 fee for processing a returned or NSF check. We reserve the right to reject check payments once a returned or NSF check occurs.

Short Notice Cancellations, Broken Appointments or Disconnected Numbers:

We truely value and respect your time and our goal is to be "On Time All The Time". We accomplish this by not overbooking our schedules as most medical offices do. Your appointment time is a reserved time for you and only you. Each time a patient does not keep their appointment; other patients who do keep their appointments are penalized. Frequent cancellations by other patients may also restrict your ability to get the appointment time you need or desire.

In order to insure mutual respect for your time and ours, our office does have a **$25** missed appointment fee for all no shows and/or short notice cancellations (less than 48 hrs notice). To help avoid any missed appointment fees we kindly request a minimum of 48hrs notice for any reschedules or cancellations.

We require a good primary phone number for appointment confirmation purposes. If the phone number we have on file for you is disconnected, leaving us no alternative number to reach you by, we will cancel your appointment and reserve the right to not reappoint your appointment.

Deposits:

For longer procedures many times a scheduling deposit is required. The deposit can vary based on the length of appointment or complexity of procedure you require, we will notify you if a deposit is needed.

INSURANCE:

Most insurance companies are now "deciding" which type of restorative material or treatment the patient should receive, regardless of the clinical inclination. While this office does everything possible to maximize the insurance benefits, I am aware that Bella Vista Dental, LLC will diagnose the type of restorative material or treatment that is needed due to their Standard of Care, not what the insurance company decides. This will mean for some patients, based on the insurance company's benefit plan, composite resin (tooth colored) fillings on posterior teeth will only be reimbursed at the amalgam (metal) filling rate, with the remainder of the fee due from the patient.

Dental insurance reimbursement has increased very little from the 1970's, while the cost of most everything else in life has doubled or tripled. Today dental insurance will typically cover routine maintenance and small fixes, but seldom will provide significant benefit for large or complex problems.
I understand that insurance plans are payment assistance plans, they are not designed to cover the entire costs of treatment. I understand that my dental insurance carrier may pay less than the bill for services. If the insurance claim(s) is not paid in 60 days, the balance will become my responsibility. By signing this form, I have authorized assignment of benefits directly to the practice.

I am also aware that the office reserves the right to charge 1.5% interest for any balance over 90 days old, as well as, any and all additional charges that might occur if the account is turned over for collection and/or attorney services are required.

Signed_____ Date_____

Bella Vista Dental, LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: (____) _____-_____

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 Practice 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. 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 we maintain.

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

Signature_____

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 healthcare 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:_____

REVOCATION OF CONSENT

I revoke my Consent to your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance of my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature_____Date_____

INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART

Bella Vista Dental, LLC
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

Bella Vista Dental, LLC makes every effort to ensure your health information is private. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD

- Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. An example of this would include teeth cleaning services. Various units may share information about you to coordinate your needs such as lab work and prescriptions. Your record may be sent to a doctor to whom you have referred. You may plan for a friend or relative to pick you up after a procedure. A doctor or employee may believe it is in your best interest to tell your friend or relative what drug you must take that night and what will speed your recovery at home.
- Payment: We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. We also may call your dental insurance for preapproval of a service. We may give dental plan details about your treatment in order for reimbursement to us or you. If someone else is responsible for you payment, we will contact that person.
- Health Care Operations: We may use and release your record to support our business functions (for example, administrative, legal, financial activities). These uses and disclosures are imperative to operate the practice, support treatment and payment, and help patients receive the highest degree of excellence in dentistry. Activities may include measuring quality, reviewing employee performance and training.

  Here is how your dental records may be used for business operations:
  - We may call, text message or email you to remind you about or confirm an appointment, give you information regarding treatment alternatives or other health related benefits and services that may be of interest to you.
  - We may use health information to review our treatment and services.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to reasonable requests to receive confidential communications of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

❖ Business Associates

- Business associates of Bella Vista Dental, LLC provide some services related to business operations. We have a written contract that requires associates to protect your record in the course of performing their job. Ex: Attorneys, Cleaning services, Schedule Confirmation Services, Billing Services.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

❖ Emergencies: We may use or release your health information during emergencies

❖ Communication Barriers: We may use or release your health information if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release of such information.

❖ Worker's Compensation: We may release information about you to comply with worker's compensation laws or similar programs.

❖ Legal Proceedings: We may release health information about you for the following reasons: Court or Administrative order, Subpoena, or other legal process.

- Legal Requirements: We will give out medical information about you when required to do so by federal, state, or local law.
- Public Health Risks: We may release information about you to local, state, or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as:

  To prevent or control disease, injury, or disability

  To report adverse events, such as drug reactions

  To notify a person who may have been exposed to a disease

  To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence

- Military, Veterans, and National Security: if you are a member of the armed forces, we may release information about you as required by military authorities.

- Law Enforcement: We may release your health information to a law enforcement official: In response to a court order, subpoena, warrant summons, or similar legal process. In response to criminal conduct at this facility. In an emergency to report a crime: the location of a crime or the identity, description, or location of the person who committed the crime.

- Amend: Should you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition as long as the record is kept by Bella Vista Dental, LLC. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request to modify medical record in these cases:
  - The current information is accurate and complete.
  - It is not part of the medical information kept by Bella Vista Dental, LLC
  - The record was not created by us.

If we deny this request you have the right to file a statement of disagreement. We may then prepare a rebuttal and provide you with a copy.

- Accounting of Disclosures: You have the right to request an "accounting of disclosures," a list of disclosures made about you other than treatment, payment or business operations.

Request this list by writing to Bella Vista Dental, LLC, P.O. Box 31625 Greenville, S.C. 29608. Your request may state a period of time, which may not be longer than six years and may not include a date before April 1, 2015.

The first list you request within a 12 month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

- Request Restrictions: You have the right to request that we limit information we use or give out about you for treatment, payment, or business operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a treatment that you had to your family.

  We are not required to agree to your request! If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information agreement form to Bella Vista Dental, LLC, P.O. Box 31625, Greenville, SC 29608. Please state (1) what you want to limit (2) if you want to limit use, release, or both (3) to whom the limits should apply, for example disclosures to your family.

- Request Confidential Communications: You have the right to request that we interact with you about medical conditions and treatment in a certain way or place. For example, you can ask that we contact you only by mail or only at work.

  To request confidential communications, submit a Restriction of Information Agreement Form to Bella Vista Dental, LLC, P.O. Box 31625, Greenville, SC 29608. We will try to meet all reasonable requests. You must state how or where you wish to be contacted.

- Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. For a copy, call Bella Vista Dental, LLC at (864) 501-0070 or request a copy by coming into the office.

- Complaints: Should you believe that your privacy has been violated, you may file a complaint with Bella Vista Dental, LLC or with the Secretary of the Department of Health and Human Services. To file a complaint, call the Practice Administrator of Bella Vista Dental, LLC at (864) 501-0070 or contact the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201.

- Other Uses: Other uses and disclosures of medical information covered by this Notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. Revocation of consent may impair reimbursement from insurance companies for your treatment. Note: We cannot take back disclosures already made with your consent.