Dr. Jillian M. Barras
Chart #:

Patient Information

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

Gender: _____ Family Status: ☐ Single ☐ Married ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ Driver's License _____

Email Address: _____

Phone (Home): _____ (Cell): _____ Best time to call: _____

Address: _____

_____

Employer Name: _____ Occupation: _____

Spouse's Name _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Internet ☐ Magazine ☐ Walk-in ☐ Work ☐ Other _____

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

Two People to contact in case of emergency:

Name _____ Telephone # _____

Address _____

Name _____ Telephone # _____

Address _____

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: _____

Secondary

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: _____

Responsible Party Information

Person Responsible for Account: Name: _____

☐ Patient ☐ Father ☐ Mother ☐ Guardian

Method of Payment: ( ) Check ( ) Visa/MasterCard ( ) Cash ( ) CareCredit

Authorization: I hereby authorize payment directly to Dr. Jillian M. Barras, D.D.S., P.A., of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

• Signature of Responsible Party Date

Health Information

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

Dental History: Would you describe your present dental health as good? ☐ Yes ☐ No

If no, please explain: _____

- Do you think you have active decay or gum disease? ☐ Yes ☐ No
  Please explain: _____
- Do your gums ever bleed? ☐ Yes ☐ No
  If yes, when? _____
- How often do you brush?_____ Floss? _____
- Do you feel nervous about dental treatment? ☐ Yes ☐ No
- Have you ever had a bad experience in a dental office? ☐ Yes ☐ No

Describe _____

- Have you ever had braces? ☐ Yes ☐ No
- Is your water fluoridated? ☐ Yes ☐ No
- Have you had any prior dental trauma? ☐ Yes ☐ No

If yes, please explain: _____

- Do you like your smile? ☐ Yes ☐ No

If no, please explain: _____

- Name of previous dentist_____

Medical History: Medical Doctor's Name & Phone # _____

- Are you under a physician's care now? ☐ Yes ☐ No

If yes, please explain: _____

- Have you been hospitalized in the past two years? ☐ Yes ☐ No

If yes, please explain: _____

- Are you taking any medications, pills, drugs, or herbal supplements? ☐ Yes ☐ No

If yes, please describe what, why, and dosage: _____

_____

_____

_____

- Are you allergic to penicillin, codeine, or any other medication? ☐ Yes ☐ No

If yes, list medication & describe reaction: _____

- *(Women)* Pregnant or nursing? ☐ Yes ☐ No
- Do you take premedication for dental treatment? ☐ Yes ☐ No
- Do you smoke? ☐ Yes ☐ No E-Cigarettes? ☐ Yes ☐ No
- Do you use alcohol? ☐ Yes ☐ No
- Are your immunizations up to date? ☐ Yes ☐ No
- **Are you allergic to latex? ☐ Yes ☐ No**

Have you ever had any of the following? Please check those that apply:

☐ Heart Trouble	☐ Chest Pain	☐ Asthma	☐ Xray or Cobalt Tmt.	☐ Hemophilia/Bleeding
☐ High Blood Pressure	☐ Shortness of Breath	☐ Sinus Trouble	☐ Arthritis/Gout	☐ HIV Positive
☐ Heart Murmur	☐ Faintness or Dizziness	☐ Lung Disease	☐ Rheumatism	☐ Aids
☐ Mitral Valve Prolapse	☐ Stroke	☐ Tuberculosis	☐ Alcohol Addiction	☐ Venereal Disease
☐ Rheumatic Fever	☐ Diabetes	☐ Liver Disease	☐ Cortisone Medicine	☐ Cold sores/fever blisters
☐ Congenital Heart Lesion	☐ Excessive Thirst	☐ Hepatitis A (Infect)	☐ Glaucoma	☐ Herpes
☐ Artificial Heart Valve	☐ Artificial Joint/Hip	☐ Hepatitis B (Serum)	☐ Epilepsy or seizures	☐ Eating Disorders
☐ Heart Pacemaker	☐ Kidney Trouble	☐ Hepatitis C (Serum)	☐ Hypoglycemia	☐ Psychiatric Problems
☐ Heart Surgery	☐ Ulcers	☐ Yellow Jaundice	☐ Chemotherapy	☐ Frequent Headaches
☐ Blood Disease	☐ Allergies	☐ Cancer	☐ Drug Addiction	☐ ADD/DHD
☐ Anemia	☐ Scarlet Fever	☐ Thyroid Problem	☐ Pain in Jaw Joint	

Please list any other serious illness if not indicated above_____

- I understand that if any change occurs in my health, I am to report it to the dental office as soon as possible; I have read, and understand each question and have answered all of them truthfully and to the best of my ability; I have discussed my health history with the doctor.

_____ _____

Signature of patient, parent or guardian Date

_____ _____

Signature of Doctor Date

FINANCIAL OPTIONS

Our Commitment is to provide dental care to the entire family through exceptional service and the utilization of up-to date technology.

METHODS OF PAYMENT

Cash, personal or cashier's check, Visa/ MasterCard, or Care Credit

DENTAL INSURANCE

We are pleased you have dental insurance, and our office would like to continue filing your insurance for you as a courtesy! We will assist you in obtaining the maximum benefits specified in your contract. However, **your insurance contract is between you, your employer, and the insurance company. Please understand that, regardless of what your insurance company pays, you are responsible for your dental bill.**

We will need you to bring us a copy of your benefit booklet if you would like help interpreting your benefits. Understand that we can only estimate what your insurance company will pay; not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will cover.

We ask that your estimated co-payment and deductible be paid at time of service as we cannot use a "wait and see" policy with insurance benefits. Insurance companies take from 30 to 60 days to pay a claim and often require further information from our office or from you before they will process a claim.

If you do not have insurance, we require the full amount at the time of service. The office staff will be glad to assist you in estimating what your fee will be, **but please remember it is only an estimate!**

Your appointment time has been reserved exclusively for you. A 48 hour notice is needed for any change in your appointment as this affects many patients. If you cancel your appointment within 48 hour notice, a $50 broken appointment fee will be applied to your account.

I have read and understand the above information. I understand that I am responsible for any charges incurred from services rendered.

Signature_____

Date_____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Port City Family and Cosmetic Dentistry
Jillian M Barras DDS PA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____