Welcome to Incline Family Dentistry

We look forward to serving you as your dental provider. Please fill out the front & back of these forms.

How did you hear about our office? _____

Patient Information

First Name _____ Last Name _____ Preferred Name _____

Date of Birth _____ SSN _____ □ Male □ Female □ Unspecified

Address _____ Home Phone _____

City _____ State ____ Zip _____ Cell Phone _____

Email _____ Work Phone _____

I would like to receive appointment reminders by email: □ Yes □ No By text message: □ Yes □ No

Status (please circle): Married Single Minor Other _____

For child, teenager, or other dependent, please list parent/guardian information:

Name _____ Cell Phone _____

Name _____ Cell Phone _____

Emergency Contact Name _____ Relationship _____

Phone Number _____ Alternate Phone Number _____

Responsible Party Information □ Self (skip to insurance section) □ Spouse/Significant other

First Name _____ Last Name _____ Preferred Name _____

Date of Birth _____ SSN _____ □ Male □ Female

Address _____ Home Phone _____

City _____ State ____ Zip _____ Cell Phone _____

Email _____ Work Phone _____

Insurance Benefits information (if applicable):

Dental Insurance Company _____ Phone _____

Policy Holder Name _____ Date of Birth _____

Policy Holder SSN/ID _____ Group # _____ Employer _____

I authorize the release of information relating to claims for my dental treatment. I understand that my patient portion is due at the time of service unless otherwise arranged prior to treatment and that any portion not covered by my insurance is my responsibility. I hereby authorize payment directly to Travis Barr DDS, PLLC (DBA: Incline Family Dentistry) of the group insurance benefits otherwise payable to me. I understand if I do not release payment, I will have to pay all dental fees at time of service and be reimbursed by insurance upon independent claim submittal and processing. I understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days.

_____ _____

Signed (Patient or Parent/Guardian if minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I have received a copy of Incline Family Dentistry's Notice of Privacy Practices.

_____

Patient printed name

_____ _____

Signed (Patient or Parent/Guardian if minor) Date

HIPAA Right of Access Form for Family Member(s) or Friend (Optional)

I, _____, direct my dental health care provider(s) and payers to disclose and release my protected health information to (may be left blank):

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

This authorization shall be effective for all past, present and future periods unless revoked. You may revoke this authorization at any time by notify your dental health care provider in writing.

_____ _____

Signed (Patient or Parent/Guardian if minor) Date

For office use only:

We attempted to obtain written acknowledgement of receipt to of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other:_____

_____ _____

Employee Signature Date

Medical History

Patient Name _____ Date of Birth _____ Height _____ Weight _____

Date of last physical _____ Please rate your health: □ Good □ Fair □ Poor

Are you under any medical treatment now? _____

Physician contact information: _____

Have you had any surgeries or been hospitalized in the past 12 months? □ Yes □ No

Have you had any accidents involving your head or jaws? □ Yes □ No

Do you have or have you had any of the following (circle all that apply)?

High blood pressure	Low blood pressure	Blood disorder	Stomach/gut disease
Heart Attack(s)	Lung/respiratory disease	Liver disease	Diabetes (type 1 or 2)
Mitral valve prolapse	Cancer or Tumors	Kidney/Urinary disease	Hepatitis (A B C D E)
HIV/AIDS	Epilepsy or Fainting	Abnormal bleeding	Autoimmune disease
Muscle/Bone disease	Bisphosphonate use	Skin disease	Other (please list)

Are you **allergic** to any of the following (circle all that apply):

Penicillin	Local anesthetic	Sulfite	OTC pain meds
Other antibiotics	Opioids	Latex	Shellfish
Nuts	Plastic	Other (please list)	

Do you require antibiotics before dental treatment? □ Yes □ No

Do you have any artificial joints (knee, shoulder, hip, etc.)? □ Yes □ No

Have you had an organ transplant? □ Yes □ No

Have you had any heart surgery? □ Yes □ No

Have you ever been treated for cancer, had radiation or chemotherapy? □ Yes □ No

Have you taken, are you taking or are you scheduled to begin bisphosphonates? □ Yes □ No

Do you currently or have you ever smoked or use tobacco (smoking, snuff, chew, bidis)? □ Yes □ No

Do you currently consume alcohol? If so, number of drink per week:_____ □ Yes □ No

Do you use marijuana? □ Yes □ No

Do you use prescription or street drugs or other substances for recreational purposes? □ Yes □ No

Are you a recovering drug addict or alcoholic? □ Yes □ No

Are you currently pregnant or breast-feeding? □ Yes □ No

List anything else I should know? _____

Please list all medications by name and dose (provide separate list if available)

_____

_____

_____

_____

_____

If all boxes are marked no and/or left blank then patient denies history of heart, lung, liver and kidney disease, hepatitis, HIV/AIDS, diabetes, immune disorder, neurologic or psychiatric disorder, malignancy (chemo/radiation therapy), bleeding disorder and drug allergy.

New Patient Oral Health Questionnaire

1. What is the reason for your dental visit today?

2. Are you nervous at dentist visits? ☐ Yes ☐ No

3. Are you interested in changing your teeth? ☐ Yes ☐ No

4. If so, what would you like to change?

☐ Whiter Teeth	☐ Straighter Teeth
☐ Replace Missing Teeth	☐ Gaps or Spaces
☐ Misshapen Teeth	☐ Healthy Teeth
☐ Better Chewing Function	☐ No pain/sensitivity

5. When was your last dental visit or cleaning? _____

6. Do your gums bleed when your brush and/or floss? _____

7. Do you clinch, grind, break teeth or have short teeth? ☐ Yes ☐ No

8. When discussing your oral health, how would you like your information?

☐ Big Picture ☐ Some Details ☐ I want to Know Everything

CERTIFICATION: I certify to the best of my knowledge the previous statements (medical and dental questionnaires) are true and factual. Any misrepresentation releases liability of Incline Family Dentistry and its employees. A comprehensive dental examination policy exists in our office. A modified or limited examination may be performed at my request, which limits liability accordingly. I consent to allow the doctor to examine my oral conditions. Based on the results of the examination, a diagnosis and proposed treatment plan and options, including consequences of no treatment, will be explained to me at which time it will by choice to proceed.

_____ _____

Signed (Patient or Parent/Guardian if minor) Date

TREATMENT AUTHORIZATION AND ACKNOWLEDGEMENT

The undersigned hereby authorizes Doctor to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with treatment and further authorize and consent that Doctor to choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. In the case of a dental emergency, I consent to treatment as deemed necessary by the Doctor for myself and/or child, understanding that the procedures will be explained in advance if I am available and conscious. If I am not available or conscious I authorize the Doctor to provide emergency treatment for me and my family as deemed appropriate by the doctor. I understand that the practice of dentistry involves living tissue and no results can be guaranteed.

BROKEN/MISSED APPOINTMENTS

Our office calls/emails/texts to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. This is time reserved specifically for you. If you cannot make an appointment as scheduled, please notify the office 24 hours before your scheduled appointment. We reserve the right to charge $25 per 30 minutes of scheduled time for a broken, cancelled or missed appointment.

FINANCIAL POLICY

I authorize the release of information relating to claims for my dental treatment. I understand that my patient portion is due at the time of service unless otherwise arranged prior to treatment and that any portion not covered by my insurance is my responsibility. I hereby authorize payment directly to Travis Barr DDS, PLLC (DBA Incline Family Dentistry) of the group insurance benefits otherwise payable to me. I understand if I do not release payment, I will have to pay all dental fees at time of service and be reimbursed by insurance upon independent claim submittal and processing. I understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. We accept cash, checks, most major credit cards and Care Credit. If a check is returned a $25 charge will be added to the account.

We are dedicated to patient care and value the relationships we have with our patients. If you have any questions regarding our policies please speak with our office.

_____

Patient printed name

_____

Signed (Patient or Parent/Guardian if minor) Date