BRIAN HOMANN, DDS, P.C.

Welcome to our Practice

Patient Name: Last_____ First_____ MI____ Preferred Name _____

Title: Mr./Ms./Mrs./etc._____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date:_____ SS #: _____

Email Address: _____

Phone: Home_____ Work_____ Ext. _____

Mobile_____ Fax_____ Other _____

Address_____ City_____ State_____ Zip Code _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Phone: _____

Address_____ City_____ State_____ Zip Code _____

How did you hear about our practice?

☐ Friend/Family/Colleague ☐ Google ☐ Yelp

☐ Dental Specialist ☐ Print Material ☐ Community Event

If referred by a friend, family member, or colleague, whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please write Name and Phone number below:

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is different than the patient or if you are the parent/guardian of the patient

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: Last_____ First_____ MI____ Preferred Name _____

Title: Mr./Ms./Mrs./etc._____ Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date:_____ SS #:_____ Driver's License #: _____

Email Address:_____ Best time to call:_____

Phone: Home_____ Work_____ Ext. _____

Mobile_____ Fax_____ Other _____

Address_____ City_____ State_____ Zip Code _____

Primary Dental Insurance:

Name of Insured: Last_____ First_____ MI _____

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

Insured's Address_____ City_____ State_____ Zip Code_____

Insured's Employer Name: _____

Insured's Employer Address_____ City_____ State_____ Zip Code_____

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

Insurance Plan Name: _____

Insurance Address_____ City_____ State_____ Zip Code _____

Insurance Company Phone Number: _____

Insurance Authorization:

I authorize my insurance company to pay the dentist all insurance benefits rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____ Date: _____

This page only needs to be filled out if the patient has a second form of dental coverage. PLEASE LEAVE THIS PAGE EMPTY IF THE PATIENT DOES NOT HAVE SECONDARY DENTAL COVERAGE.

Secondary Dental Insurance:

Name of Insured: Last_____First_____MI _____

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

Insured's Address_____City_____State_____Zip Code _____

Insured's Employer Name:_____

Employer Address_____City_____State_____Zip Code_____

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

Insurance Plan Name:_____

Insurance Address_____City_____State_____Zip Code_____

Insurance Company Phone Number: _____

Insurance Authorization:

I authorize my insurance company to pay the dentist all insurance benefits rendered.

I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature:_____ Date: _____

BRIAN HOMANN, DDS, P.C.
Dental Information

Patient Name: Last_____First_____MI____Preferred Name _____

How would you rate the condition of your mouth: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number: _____

Approximate date of most recent dental exam and dental x-rays: _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?_____

If there anything about the appearance of your smile that you would like to change? _____

Check all that apply:

☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ Experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Experienced popping and/or clicking of your jaw joint
☐ Have difficulty chewing
☐ Clench or grind your teeth
☐ Wear or have worn a bite appliance
☐ Gums bleed when brushing or flossing
☐ Notice an unpleasant taste or odor in your mouth
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury)
☐ Experienced a burning sensation in your mouth
☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe: _____

Medical Information

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response leaving blank will indicate a "NO" response.

☐ *Pre-Med - Amoxicillin
☐ *Pre-Med - Clindamycin
☐ *Pre-Med - Other
☐ A - Fib
☐ Allergy - Aspirin
☐ Allergy - Codeine
☐ Allergy - Latex
☐ Allergy - Other
☐ Allergy - Penicillin
☐ Allergy - Sulfa
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Bisphosphonate Use
☐ Blood Disease
☐ Blood Thinners
☐ Breastfeeding
☐ Cancer
☐ COPD
☐ Diabetes
☐ DVT
☐ Emphysema
☐ Endocarditis
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Head Injuries
☐ Hearing Loss
☐ Heart Disease
☐ Heart Murmur
☐ Heart Valve Surgery
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Jaundice
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Low BP
☐ Mental Illness
☐ MVP
☐ Nervous Disorders
☐ Osteoporosis
☐ Other / Not Listed
☐ Pacemaker
☐ Pregnant
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seasonal Allergies
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problem
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Tobacco Use
☐ History of Drug Addiction
☐ Subject to frequent headaches
☐ FEMALE: Taking birth control pills
☐ Ever been hospitalized (illness or injury)
☐ Drink alcohol daily or had more than 5 alcoholic beverages on a single day within the last 30 days
☐ Wear hearing aids or have hearing loss
☐ Have you ever taken Fosamax, Boniva, Actonel, or medications containing bisphosphonates
☐ Do you have any allergies not previosly listed
☐ Heart transplant with abnormal heart valve function
☐ Cyanotic congenital heart disease that has not been fully repaired
☐ Repaired congenital heart disease with residual defects
☐ _____
☐ _____
☐ _____
☐ _____

If any conditions or alerts selected need further clarification, please describe below: _____

Do you take antibiotic premedication for your dental visits? If yes, please explain._____

Name of your physician and phone number: _____

Previous Surgeries: _____

Please list all past surgeries as well as any current medical treatment, impending surgery, or other treatment not previously listed.

List all medications (prescription and non-prescription) including regular doses of aspirin:

There are no other medical conditions or medications/allergies that have not been listed. I will not hold Brian Homann, D.D.S. or his staff responsible for any errors or omissions that I may have made in the completion of this form. I am aware that I must notify the practice of any future changes. I acknowledge that I have reviewed and understand all areas of this form and responded accordingly. I acknowledge that my questions, if any, about the inquiries section forth above have been answered to my satisfaction.

Signature:_____ Date:_____

Consent for Services and Financial Policy

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for the entire payment of all dental services. The office of Brian Homann DDS will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. I am aware that some or perhaps all of the services provided may be non-covered services. An example of such a service is a tooth colored composite filling. Many insurance companies only pay for metal fillings.

I understand that insurance is a contract between the patient and the insurance company and that the office of Brian Homann DDS is not part of this contract.

I understand that I am responsible for all costs of dental treatment.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment. I authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I understand the above information and agree to its contents.

Signature:_____ Date: _____

HIPAA Acknowledgement

I have received, read, and understand the Notice of Privacy Practices. I understand that Brian Homann DDS has the right to change the Notice of Privacy Practices and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that at any time, this authorization may be revoked. Revocation becomes effective when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting the confidentiality.

I understand that I may refuse to sign this acknowledgement.

I understand the above information and agree with its contents.

Signature:_____ Date: _____

FOR STAFF USE ONLY

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

☐ Individual refused to sign

☐ Communications barriers prevented obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other

If other, please specify:_____ Date: _____

Consent For Electronic Communications

Our office always strives to make going to the dentist more convenient for our patients. We now are able to provide limited information via text messages and email. With any type of electronic communication there is a risk that the message may be read by a third party. Here are some things you should know regarding electronic communication:
1) Type of information to be transmitted: Dr. Homann plans to send information such as appointment reminders, recall notices, and satisfaction surveys via text and email. Dr. Homann may also send out information pertinent to your care, including, but not limited to, medication reminders.
2) What each message will contain: The messages may contain your (or your family member's) name, your appointment time and date, pertinent care reminders, acknowledgement that you are a patient of the practice, and/or an acknowledgement that you were seen for a visit.
3) What is at risk: The information stated above has the possibility of being intercepted and could be read by a 3rd party, as the text or email will be sent via method that is not encrypted to HIPAA compliant standards.
4) If information needs to be communicated that contains more information than above, such as copies or x-rays, that information will be sent via a HIPAA compliant, password protected email.

Until I tell you in writing to stop, I authorize Brian Homann DDS to transmit patient information relating to my treatment and health by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, or Brian Homann DDS's health care services.

I understand that:
- I do not have to consent to use of electronic communications.
- My treatment, payment, enrollment and eligibility or benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Brian Homann DDS may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy laws.
- Brian Homann DDS does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect email that Brian Homann DDS already sent before receiving my written instructions to stop.

I consent to receiving electronic communication from Brian Homann DDS, PC. ☐ Yes ☐ No

If you said "Yes" to the previous question, please fill out the remaining information. If you answered "No" please sign the document and leave the other 2 questions empty.

I consent to receive electronic communication via text message. ☐ Yes ☐ No

I consent to receive electronic communications via email. ☐ Yes ☐ No

I acknowledge that I have read the above statements and agree to the contents.

Signature:_____ Date: _____

Consent For Use Or Disclosure Of Protected Health Information

For the convenience of our patients, we allow permission to be given to access and discuss your dental treatment to people of your choosing. For example, if you would like your spouse to be able to talk to the dentist about any or all aspects of your treatment and dental history, this form would allow your protected health information to be discussed with the person or persons of your choosing.

Authorized to Release to the Following Individuals. If you would not like anyone other than yourself to have access to your records, please write NONE. Please list name and relation of each individual.

_____

I authorize the release of my confidential and protected dental information to the individuals listed above. I understand that this authorization is voluntary and that the information to be disclosed is protected by law. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information. I understand my treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form. I may withdraw my consent at any time by notifying the office of Brian Homann DDS in writing. I consent to release my entire dental record and medical history unless noted in the "Excluded" section below.

By selecting "Yes" I acknowledge that I have read the above statements and agree to the contents. By selecting "No", I acknowledge that I have read the above statements but do not wish to disclose information to anyone other than myself. ☐ Yes ☐ No

Information to be excluded (if any): _____

Signature:_____ Date: _____