Jonathan Burbank, DDS
107 Centre Sarcelle Blvd., Ste 705
Youngsville, LA 70592

We warmly welcome you to our office. Please complete the following so that we can better care for you. Please print.

PATIENT INFORMATION

Circle one: Dr/Mr/Mrs/Ms/Miss

First: _____ Middle: _____

Last:_____ Jr/Sr:_____

Address: _____

City:_____State:_____Zip:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Email address:_____

Patient Social Security Number: _____ Date of Birth:_____

Sex: (circle) **M F**

Responsible Party: _____ Phone: _____

Relation: _____

Emergency Contact: _____ Phone: _____

Relation: _____

How did you hear about us? **(Circle One)** Yellow Pages Newspaper Mailer-Brochure Referral Card

Google Outdoor Sign Other: _____

How do you prefer us to confirm appointments? Email Phone Both

DENTAL INSURANCE

Do you have dental insurance? (circle) Y N Do you have a secondary dental insurance? Y N

Please state your name as it is recorded with your dental insurance company:_____

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees. Patient portion is due in full at time of treatment.

DENTAL AND HEALTH INFORMATION

Reason for today's visit? _____

Date of last dental visit? _____Date of last dental x-rays?_____

Why did you leave your last dentist? _____

What treatment would you like to have completed?

_____

Are you interested in the following? (please circle)

Smile Makeover Whitening Sedation Dentistry Cosmetic Dentistry

Sealants Invisalign Braces Veneers Dental Implants

Have you ever been hospitalized for illness or injury? What for?_____

Do you have a history of: (Circle Yes or No)

Epilepsy/Seizures	Y N	Date_____	Psychiatric Disorder	Y N
Chemical Dependency	Y N		Recurrent Bronchitis/COPD	Y N
High Blood Pressure	Y N		Pneumonia	Y N
Heart Surgery	Y N		Hepatitis (Type A, B or C)	Y N
Heart Attack	Y N	Date_____	Kidney Failure	Y N
Stroke	Y N	Date_____	HIV/AIDS	Y N
Chest pains/Angina	Y N		Osteoporosis	Y N
Congenital Heart Disease	Y N		Joint Replacement Surgery	Y N
Diabetes	Y N		Stomach/Intestinal/Colon Disease	Y N
Anemia/Hemophilia	Y N		Skin Disorders	Y N
Venereal Disease	Y N		Asthma	Y N
Cancer	Y N		Mitral Valve Prolapse	Y N
Pacemaker	Y N		Glaucoma	Y N
Artificial Heart valve	Y N		Lumps or sores in mouth	Y N
Head or neck radiation	Y N		Endocarditis	Y N

Past Surgeries? (Include date):

_____

_____

Describe any other medical treatment, illness, or upcoming surgery not listed elsewhere on this form that may affect your dental treatment:

_____

ALLERGIES: Penicillin?____ Sulfa?____ Latex?____ Aspirin? ____ Codeine? ____ Fluoride? _____

Allergies to any other medications? _____

Do you smoke? _____ Packs per day? _____ Dip/Chewing tobacco? _____

Do you drink? _____ Drinks per week? _____

LADIES ONLY: Are you pregnant? _____ If so, what month? _____

MEDICATIONS:

List ALL medications you are currently taking:

_____

_____

_____

I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical conditions or medications. I hereby certify that the medical and dental history provided is correct to the best of my knowledge and give my consent for the Burbank Family Dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature:_____ Date:_____

FINANCIAL POLICY

In our continued commitment to provide the highest quality of dental care available to all our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment:

- VISA, Mastercard, American Express, Discover at time of service
- Care Credit

As a courtesy, we will process your insurance benefits in our office. We must emphasize that as a dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received of your claim is denied, you will be responsible for paying the full amount. I authorize Burbank Family Dental to release any

dental information necessary to process dental insurance claims. I also request and authorize payments of any benefits, applicable to services rendered, to Burbank Family Dental.

I agree that I am fully responsible for the total payment of all procedures performed in this office, and this includes any diagnostics or treatment that is not a benefit of any dental insurance that I may have. In the event that your insurance carrier pays less than the estimated amount or your treatment is not covered due to limitations, exclusions, or waiting periods, you are responsible for the unpaid balance. I understand that all services are due to be paid in full within sixty (60) days of date of service, regardless of whether or not my insurance benefits have been received. Be aware that any unpaid balance after 60 days is charged a yearly finance charge of 18% and that this finance charge is equal to 1.5% of the outstanding balance per month. If the account reaches collections status and no effort is made to pay it off, the account will be assigned to a collection attorney or agency. If the doctor must take additional steps to collect the account, all costs of collection including court costs and attorney's fees incurred by the doctor will be charged to the patient.

Appointments and Cancellations

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least **48 hour notice**. This courtesy makes it possible to give your reserved room to another patient who would like it.

We reserve the right to charge a $50.00 per hour missed appointment fee for broken/missed appointments. We understand emergencies and unexpected events occur, but if two missed appointments or broken appointments occur without 48 hour notice, a $50/hour fee will be imposed.

Thank you for taking time to read our financial policy. Please let us know if you have any questions.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you have any questions, please ask our office manager or dentist.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

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

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

New Patient Consent Form

Consent for Dental Exam, X-Rays and Treatment Planning and Acknowledgement of Receipt of Information
State law requires us to obtain your consent for the contemplated dental exam, x-rays and treatment planning. What you are being asked to sign is confirmation you understand the nature and purpose of your visit and the risks associated therewith. Ask about anything you do not understand. We will be pleased to explain.
I hereby authorize and direct **Burbank Family Doctors**, assistants, and hygienist to perform upon _____ the following dental procedures:
Dental exam, x-rays and treatment planning

RISK ASSOCIATED WITH THE ABOVE PROCEDURES:
I understand that dentistry is not an exact science and that complications may occur despite our best efforts. A partial listing of the risks known to be associated with these procedures:

- Pain
- Allergic reaction to latex gloves

- Stretching of the mouth, which may cause bruising or result in cracking

PHOTOGRAPHS:
I hereby specifically authorize the above doctors and staff to take, develop and use photographs at all phases of my treatment for educational, demonstrative and/or promotional purposes specifically including use in lectures and publications and I do hereby forever waive any claim to royalties or other monies or other sources of reimbursement that are received from their use.

ACKOWLEDGEMENT
I acknowledge that I have read and I understand the information contained in this consent form (or that it has been read to me).
I hereby authorize **Burbank Family Dental** and their dentists, hygienists, or assistants of their choice to perform the dental exam, x-rays and treatment planning. This Consent Form will remain valid until revoked by me in writing. All blanks were filled in prior to my signature. I waive further disclosures or information.

Date_____

Signature of Patient_____

Signature of Parent/Guardian_____
Relationship to Patient: _____ (if under age of 18)

Dentist_____

Witness_____