PIONEER PERIODONTICS & IMPLANT DENTISTRY, PC

JOHN E. RUTLEDGE, DDS, MS
Diplomate of American Board of Periodontology
HOANG-OANH T. LE, DDS, MS
Diplomate of American Board of Periodontology
AARON D. BRADLEY, DDS, MS
Diplomate of American Board of Periodontology
PAULA C. SCHLEMMER, DMD, MS

Patient First Name:_____ MI:____ Last Name: _____

Street Address: _____

City, State, Zip Code:_____

Telephone: Best number to reach you: _____ Alternative Number(s):_____

E-mail:_____

Date of Birth: _____ Sex: _____ Age: _____

Employer: _____ Occupation: _____

Students: School of Attendance: _____

Marital Status: (circle) Single Divorced Widowed Married: Spouse's Name:_____

Other Emergency Contact Name/Telephone: _____

Parent(s) Name (if patient is a minor, under 19): _____

Address:_____ Telephone:_____

General Dentist: _____

Other Referring Dentist: _____

Primary Care Physician: _____ Telephone: _____

Preferred Pharmacy: _____ Telephone: _____

**BILLING//RESPONSIBLE PARTY INFORMATION**

Name: _____

Address:_____

Telephone: _____

Do you have dental insurance? _____Primary Insurance Carrier:_____

Secondary Insurance Carrier: _____

*To the best of my knowledge, all of the preceding answers are true and correct. I understand that I am financially responsible for all dental services provided by Periodontal Offices, PC, regardless of dental insurance coverage, which is a contract between the insurance company and the employee. I also authorize the release of my records or dental information, as may be required.*

_____ _____

****Patient/Responsible Party Please Sign**** **Date**

4200 Lucile Drive, Suite 100 | Lincoln, NE 68506 | 402.483.7631 | FAX 402.483.1237
info@pioneerperiodontics.com | www.pioneerperiodontics.com

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Patient Name _____ Date of Birth _____

PREMEDICATIONS
- Y N Organ Transplant
- Y N Artificial Heart Valve
- Y N Artificial Joints

CARDIOVASCULAR SYSTEM
- Y N Angina Pectoris-Chest Pain
- Y N Congenital Heart Defect
- Y N Mitral Valve Prolapse
- Y N Pacemaker
- Y N Rheumatic Heart Disease/Fever
- Y N Stroke/Blood Clots
- Y N Heart Attack/Heart Surgery
- Y N High Blood Pressure
- Y N Low Blood Pressure
- Y N History of Endocarditis

BLOOD – LYMPHATICS
- Y N Anemia
- Y N Blood Disorders
- Y N Abnormal Bleeding
- Y N Blood Transfusion

RESPIRATORY SYSTEM
- Y N Asthma/Emphysema
- Y N COPD
- Y N Tuberculosis
- Y N Sinus Problems
- Y N Seasonal Allergies

NERVOUS SYSTEM
- Y N Seizures
- Y N Epilepsy
- Y N Neuritis/Neuralgia/Numbness
- Y N Depression

BONES and JOINTS
- Y N Osteo/Rheumatoid Arthritis
- Y N Back, Neck, Jaw Injury

ENDOCRINE SYSTEM
- Y N Diabetes
- Y N Thyroid Problems

GENITOURINARY/GASTROINTESTINAL
- Y N Kidney Disease
- Y N Stomach/Intestinal Problems
- Y N Liver Disease
- Y N Jaundice
- Y N Ulcers, Reflux Disease
- Y N Eating Disorders

INFECTIOUS DISEASES
- Y N Hepatitis (A,B,C, or other)
- Y N AIDS, ARC, HIV, ANTI-HIV
- Y N Venereal Disease
- Y N Cold Sores

GENERAL
- Y N Cancer-Chemotherapy
- Y N Radiation Therapy
- Y N History of Bisphosphonate Use
- Y N Deafness
- Y N Eye Problems- Glaucoma
- Y N Alcohol abuse
- Y N Drug Abuse

SMOKING/TOBACCO USE
- Y N Do you smoke/use tobacco
  Packs/Day/Year _____

WOMEN
- Y N Are you pregnant
- Y N Using Birth Control
- Y N Are you nursing

ALLERGY: Are you allergic/had a reaction to:
- Y N Aspirin
- Y N Codeine
- Y N Dental Anesthetic
- Y N Erythromycin
- Y N Jewelry
- Y N Latex
- Y N Metals
- Y N Penicillin
- Y N Tetracycline
- Y N Others _____

**Please list your medications (Rx, Herbal,OTC):**

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

**Hospitalizations:** _____

_____

_____

**Other conditions, otherwise not listed:**

_____

_____

_____ _____

**Signature of Patient, Parent/Guardian** **Date**

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## Consent for Use and Disclosure of Health Information

**Patient Name Giving Consent:** _____

**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 Practices 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 and of other important matters about your protected health information. A copy of our Privacy Practices is available upon request.

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 that we maintain.

**Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Pioneer Periodontics & Implant Dentistry, PC, Diane Harris, contact person. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation. We may decline to treat you or to continue treating you if you revoke this Consent.

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 health care operations.

_____ _____

****Signature of Patient/Responsible Party**** Date

**If this Consent is signed by a Parent, Guardian, or Personal Representative (PR) on behalf of the patient, complete the following:**

Parent, Guardian or PR's name: _____

Relationship to Patient: _____ Date: _____

**Revocation of Consent-Sign only if Patient wishes to revoke their Consent**
I revoke my Consent for 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 on 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 of Patient/Responsible Party**** Date

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## FINANCIAL and APPOINTMENT POLICIES

Welcome to our practice! We appreciate the opportunity to provide you with specialized care. Please read this information about our financial and appointment policies.

**If you do not have insurance, payment is expected at the time of service.** We accept cash, personal checks, VISA, MasterCard, Discover, Care Credit, and Proceed Finance. **If you have dental insurance, it is the patient's responsibility to provide the dental insurance policy information.** Please note the dental insurance contract is an agreement between you and the insurance company. You should know the details of your insurance plan. Many insurance plans require you to use certain doctors and may require precertification. It is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

**We expect payment in full for the initial examination appointment.** We will file your insurance claim as a courtesy to you, in most cases. *Even if you have insurance, payment to us is your responsibility.* You will be provided with a printed treatment plan once one is established. Payment arrangements can be discussed prior to scheduling treatment. If pretreatment estimates are requested, **please note the estimate is not a guarantee of payment by the insurance company.**

If your insurance carrier does not remit payment within the required 30 business days, the balance will be due in full from you. It is not our policy to contact carriers to establish why they have not paid or why they paid less than originally indicated since we may not be a part of your agreement with your carrier. If you wish to rebill your insurance, we will provide you with a full itemized statement for your correspondence to your insurance carrier.

**If an appointment is canceled, rescheduled, or failed within 48 hours (2 business days) prior to appointment, you will be assessed a charge of $100.00. You will be asked to make the payment prior to rescheduling. _____ (Initial)**

Accounts not paid in full within 90 days are considered past due. An interest rate of 1.5% per month will be charged on all past due accounts. There is a fee of $30.00 for each returned check.

***"I verify the accuracy of the billing information, and I realize that the responsibility for all account balances is mine. I authorize the release of any medical information necessary to proceed with my insurance claims."***

_____ **Date**_____

**Signature of patient or guardian/guarantor, if under the age of 19**