FRIENDLY SMILES COSMETIC DENTISTRY
Dr. Brenda Barfield, DDS
2701 9th Ave S, Suite F
Fargo, ND 58103

Welcome to Friendly Smiles Cosmetic Dentistry. We sincerely appreciate you choosing our office for your dental and oral health needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please complete this information packet.

PATIENT INFORMATION

PLEASE TELL US ABOUT YOURSELF:

Patient's name: _____ Home phone: _____
Address: _____ Cell phone: _____
City: _____ State: ___ Zip: _____ Date of birth: _____ Sex: M [ ] or F [ ]
How did you hear about us: _____ Social Security #: _____
Do you have dental insurance? Yes [ ] or No [ ]

If the patient is a minor, please tell us about you, the parent or guardian:

Your name: _____ Relationship to patient: _____
Your address: _____ Your phone #: _____
City: _____ State: ___ Zip: _____ Your social security #: _____

If patient is under 18 years old, he/she must be accompanied by a parent or guardian during the entire appointment. This applies to all appointments. Only a parent or guardian can sign an updated medical report and consent forms for a minor patient. If you are not a parent or legal guardian of the patient above, do not continue filling this out.

EMERGENCY CONTACT:

Name: _____ Phone: _____ Relation to Patient: _____

EMPLOYER INFORMATION:

Employer: _____ Phone: _____
Address: _____ Your position: _____
City: _____ State: ___ Zip: _____ How long with company: _____

INSURANCE CARRIER INFORMATION:

Name of insurance co: _____ Subscriber ID #: _____
Address of insurance co: _____ Phone: _____
City: _____ State: ___ Zip: _____ Group number/effective date: _____

If insurance is under a name other than you, please fill out the following:

Policy holder's name: _____ Phone: _____
Address: _____ Date of birth: _____
City: _____ State: ___ Zip: _____ Social Security #: _____
Place of employment: _____

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes [ ] or No [ ]	If yes, please explain _____
Have you ever been hospitalized or had a major operation?	Yes [ ] or No [ ]	If yes, please explain _____
Have you ever had a serious head or neck injury?	Yes [ ] or No [ ]	If yes, please explain _____
Are you taking any medications, pills, or drugs?	Yes [ ] or No [ ]	If yes, please explain _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes [ ] or No [ ]	
Have you ever taken Fossamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes [ ] or No [ ]	
Are you on a special diet?	Yes [ ] or No [ ]	
Do you use tobacco?	Yes [ ] or No [ ]	
Do you use controlled substances?	Yes [ ] or No [ ]	

WOMAN ONLY:

Are you pregnant/trying to get pregnant? Yes [ ] or No [ ] Are you taking oral contraceptives? Yes [ ] or No [ ] Are you nursing? Yes [ ] or No [ ]

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

Aspirin [ ] Penicillin [ ] Codeine [ ] Local anesthetics [ ] Acrylic [ ] Latex [ ] Sulfa drugs [ ]
Metal [ ] Other [ ] Please indicate here what other is: _____
If yes on any of these, please explain: _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?:

AIDS/HIV Positive	**Yes [ ] or No [ ]**	Cortisone Medicine	Yes [ ] or No [ ]	**Hemophilia**	**Yes [ ] or No [ ]**	Radiation Treatment	Yes [ ] or No [ ]
Alzheimer's Disease	**Yes [ ] or No [ ]**	Diabetes	Yes [ ] or No [ ]	**Hepatitis A**	**Yes [ ] or No [ ]**	Recent Weight Loss	Yes [ ] or No [ ]
Anaphylaxis	**Yes [ ] or No [ ]**	Drug Addition	Yes [ ] or No [ ]	**Hepatitis B or C**	**Yes [ ] or No [ ]**	Renal Dialysis	Yes [ ] or No [ ]
Anemia	**Yes [ ] or No [ ]**	Easily Winded	Yes [ ] or No [ ]	**Herpes**	**Yes [ ] or No [ ]**	Rheumatic Fever	Yes [ ] or No [ ]
Angina	**Yes [ ] or No [ ]**	Emphysema	Yes [ ] or No [ ]	**High Blood Pressure**	**Yes [ ] or No [ ]**	Rheumatism	Yes [ ] or No [ ]
Arthritis/Gout	**Yes [ ] or No [ ]**	Epilepsy or Seizures	Yes [ ] or No [ ]	**High Cholesterol**	**Yes [ ] or No [ ]**	Scarlet Fever	Yes [ ] or No [ ]
Artificial Heart Valve	**Yes [ ] or No [ ]**	Excessive Bleeding	Yes [ ] or No [ ]	**Hives or Rash**	**Yes [ ] or No [ ]**	Shingles	Yes [ ] or No [ ]
Artificial Joint	**Yes [ ] or No [ ]**	Excessive Thirst	Yes [ ] or No [ ]	**Hypoglycemia**	**Yes [ ] or No [ ]**	Sickle Cell Disease	Yes [ ] or No [ ]
Asthma	**Yes [ ] or No [ ]**	Fainting Spells/Dizziness	Yes [ ] or No [ ]	**Irregular Heartbeat**	**Yes [ ] or No [ ]**	Sinus Trouble	Yes [ ] or No [ ]
Blood Disease	**Yes [ ] or No [ ]**	Frequent Cough	Yes [ ] or No [ ]	**Kidney Problems**	**Yes [ ] or No [ ]**	Spina Bifida	Yes [ ] or No [ ]
Blood Transfusion	**Yes [ ] or No [ ]**	Frequent Diarrhea	Yes [ ] or No [ ]	**Leukemia**	**Yes [ ] or No [ ]**	Stomach/Intestinal Disease	Yes [ ] or No [ ]
Breathing Problem	**Yes [ ] or No [ ]**	Frequent Headaches	Yes [ ] or No [ ]	**Liver Disease**	**Yes [ ] or No [ ]**	Stroke	Yes [ ] or No [ ]
Bruise Easily	**Yes [ ] or No [ ]**	Genital Herpes	Yes [ ] or No [ ]	**Low Blood Pressure**	**Yes [ ] or No [ ]**	Swelling of Limbs	Yes [ ] or No [ ]
Cancer	**Yes [ ] or No [ ]**	Glaucoma	Yes [ ] or No [ ]	**Lung Disease**	**Yes [ ] or No [ ]**	Thyroid Disease	Yes [ ] or No [ ]
Chemotherapy	**Yes [ ] or No [ ]**	Hay Fever	Yes [ ] or No [ ]	**Mitral Valve Prolaspe**	**Yes [ ] or No [ ]**	Tonsillitis	Yes [ ] or No [ ]
Chest Pains	**Yes [ ] or No [ ]**	Heart Attack/Failure	Yes [ ] or No [ ]	**Osteoporosis**	**Yes [ ] or No [ ]**	Tuberculosis	Yes [ ] or No [ ]
Cold Sores/Fever Blisters	**Yes [ ] or No [ ]**	Heart Murmur	Yes [ ] or No [ ]	**Pain in Jaw Joints**	**Yes [ ] or No [ ]**	Tumors or Growths	Yes [ ] or No [ ]
Congenital Heart Disorder	**Yes [ ] or No [ ]**	Heart Pacemaker	Yes [ ] or No [ ]	**Parathyroid Disease**	**Yes [ ] or No [ ]**	Ulcers	Yes [ ] or No [ ]
Convulsions	**Yes [ ] or No [ ]**	Heart Trouble/Disease	Yes [ ] or No [ ]	**Psychiatric Care**	**Yes [ ] or No [ ]**	Venereal Disease	Yes [ ] or No [ ]
						Yellow Jaundice	Yes [ ] or No [ ]

Have you ever had any serious illness not listed above? Yes [ ] or No [ ] _____

Comments : _____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

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NOTICE OF PRIVACY PRACTICES

We are regulated by federal law to inform you of your rights for privacy provided by the HIPAA program, which went into law April 14, 2003.

We are required by federal law and state law to maintain privacy of your health information.

We may use or disclose your health information during treatment, to obtain payment, and in connection with healthcare operations.

We will not use your health information for marketing communications without your consent.

You have the right to obtain copies of your health information upon written request and there will be a fee charged to you.

You have the right to request that we amend your health information upon written request.

A more complete statement of Notice of Privacy Practices is available upon request.

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

_____ _____

Signature of Patient, Parent, or Guardian 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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PERMISSION FOR COMMUNICATIONS

Name of patient: _____ Patient date of birth: _____

I permit Friendly Smiles Cosmetic Dentistry, its doctors, hygienists, dental assistants, and other personnel (Health Care Providers) to discuss health information, in person, telephone, or other correspondence, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient.)

Name:	Phone Number:	Relationship:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

This authorization is limited to discussions regarding the following medical condition(s):

_____

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

This authorization is limited to the following time frame from _____(date) to _____(date).
If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify Friendly Smiles Cosmetic Dentistry.

Patient's Signature: _____ Date: _____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

FINANCIAL POLICY

Thank you for choosing Friendly Smiles Cosmetic Dentistry as your dental care provider. We are committed to your successful treatment. Please read our financial policy carefully, initial each area and sign at the bottom to proceed with your appointment.

PAYMENT:

Payment for our services is due at the time of your visit. We accept cash, Visa, MasterCard and Discover.

If a patient is 18 years of age or older and someone else is financially responsible for that person's account, financial arrangements must be made BEFORE the patient is treated if that person will NOT be accompanying the patient during the appointment. Otherwise, any person 18 years of age or older is responsible for payment before they leave our office.

In those cases of separated or divorced families, the financially responsible party MUST accompany the minor patient to his/her appointment or financial arrangements must be made BEFORE the patient is treated if that person will NOT be accompanying the patient during the patient's scheduled appointment. Otherwise, the accompanying party is responsible for payment before they leave our office.

INSURANCE:

If you have insurance coverage, we can process the insurance claim for you, and give you an estimate for the patient portion of your bill. This portion is due at the time of service. If we do not receive payment from your insurance company within 45 days, or if the insurance coverage is less than we estimated, we will send you a bill for the outstanding amount. If we overestimated the patient portion, we will promptly refund the difference upon request or credit is applied to account for future use. We will provide you with a brochure explaining how dental insurance works and request that you read it thoroughly.

Patients are responsible to know their insurance plan. Friendly Smiles Cosmetic Dentistry is not liable for anything denied or not covered by your insurance plan. When given a treatment plan in writing or verbal we are estimating insurance benefits and it is not a guarantee of payment. A preauthorization of the treatment plan is available upon request.

LATE PAYMENT:

In the event your account becomes past due, we will assess a late charge equal to 1.5% per month of your outstanding account balance. If your account becomes overdue by more than 60 days, it will be referred to an outside collection agency. You will then be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by Friendly Smiles Family Dentistry in collection of the payment.

APPOINTMENT CANCELLATION/MISSED APPOINTMENT:

Your account will be charged a $75 fee for missed appointments unless we receive notification at least 24 hours in advance.

PLEASE INDICATE BELOW THAT YOU HAVE READ AND UNDERSTAND OUR FINANCIAL POLICY.

I have read and understand this policy:

_____ _____

Signature of Patient, Parent, or Guardian Date

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CONSENT TO USE OF NAME OR PICTURE

I hereby consent that my name and/or picture or portrait of me may be used by Friendly Smiles Cosmetic Dentistry for such purposes in connection with before and after treatment that Friendly Smiles Cosmetic Dentistry has provided and may be used, exhibited, and published for educational and promotional purposes and includes any media currently in use or yet to be invented, in perpetuity.

Patient Name:

_____

_____ _____

Signature of Patient, Parent, or Guardian Date

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AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

Patient Name: _____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling 701-364-9990.

Email Address (PLEASE PRINT CLEARLY):

_____@_____

_____ _____
Signature of Patient, Parent, or Guardian Date