Patient Information:

First Name Last Name M.I.

Dr. Mr. Mrs. Ms. Miss (Please circle one)

Nickname

S.S.N. Date of Birth

Gender: M F
(Please circle one)

Street Address

City State Zip

E-Mail

( )
Home Telephone

Preferred Call Times:

Preferred Contact Method:
Home Cell Work Email
(Please circle one)

( )
Cell Telephone

( )
Work Telephone

Can you be contacted at work?
Y N
(Please circle one)

Occupation Employer

Marital Status: Single Married Divorced Widowed Separated (Please circle one)

In Case of Emergency, Please Notify:

Name Relationship

( )
Home Telephone

( )
Work Telephone

( )
Cell Telephone

( )
Pager

Other Information:

How did you hear about us?

Whom may we thank for referring you?

Responsible Party (If Different from first page):

First Name | Last Name | M.I.

Dr. Mr. Mrs. Ms. (Please circle one)

Nickname

S.S.N. | Date of Birth | Gender: M F (Please circle one)

Street Address

City | State | Zip

E-Mail | ( ) Home Telephone

( ) Cell Telephone | ( ) Work Telephone

Occupation | Employer

Marital Status: Single Married Divorced Widowed Separated (Please circle one)

Payment Agreement:

Payment for services is expected at the time service is provided. Cash and personal checks are accepted. MasterCard and VISA credit card payment are also welcome. If an extended payment plan is desired, please ask us about the CareCredit program. If you have any questions please feel free to ask.

If you have dental insurance, we will file your claim for you as a courtesy. We accept direct claim from most insurance companies. We will estimate your deductible and the portion not covered by your insurance (your co-payment), which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due to our office may be adjusted accordingly. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 90 days will automatically become the responsibility of the patient.

I understand and agree that all services rendered to me, my dependants, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment, regardless of insurance. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. In the event my account balance is referred to any agency or attorneys for collection purposes, I agree to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein. I understand that if I suspend or terminate any care and treatment to me or to any person referred to in the previous sentence, any fees for professional services rendered will be immediately due and payable.

Signature | Date

Consent for Dental Services:

Please read and initial each item and sign on this form

1) ________ *initial* Yes, I understand that tests and x-rays have to be done to find out what dental treatment I or my child need.

2) ________ *initial* I understand that following examination and having tests done (x-rays, study models, etc.) to establish treatment needs, I may or may not be referred to a specialist for some treatment needs.

3) ________ *initial* Yes, Dr. Ballrick may do the following treatment for me or my child.

   1. Take x-rays and pictures of me or my child's teeth and jaws.
   2. Give me or my child medicines to control pain during dental treatment.
   3. Prescribe drugs when I or my child need them.
   4. Do other tests to find out what dental treatment I or my child may need.

4) ________ *initial* Yes, I want Dr. Ballrick to do dental treatment for me or my child. I understand I will be told about the results of tests done, that I can ask questions at any time, that I will be told of the risks for these services, and that I will be told what may happen if I don't get dental treatment now.

5) ________ *initial* Yes, I understand that no guarantee or assurance has been given to me that the proposed treatments will fully satisfy my expectations.

6) ________ *initial* Yes, I authorize Dr. Ballrick to release to my insurance company(s) all information needed to process any claims filed.

7) ________ *initial* Yes, I understand that it is my responsibility to supply insurance information and I authorize any insurance payments directly to Dr. Ballrick II.

8) ________ *initial* Yes, I will follow office policies set forth by Dr. Ballrick II regarding my treatment and my treatment can be stopped if I or my child break the rules.

I have read and fully understand the consent form, I have signed it freely and voluntarily. All of my questions have been answered to my satisfaction.

____

Signature Date

Acknowledgement of Notice of Privacy Practices:

Your privacy is very important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. This is a summary of the more detailed information contained in our Notice of Privacy Practices. Your rights include:

- A right to inspect and request a copy of your treatment information.
- A right to request an amendment to your health information.
- A right to request restrictions on what information we use or how we disclose your health information.
- A right to receive an accounting of certain disclosures we have made of your health information.
- A right to receive a paper copy of our Notice of Privacy Practices.

These rights do have special restrictions, so it is important that you read the full Notice of Privacy Practices. We may also use your health information and/or treatment records to:

- Plan for your care.
- Help your health care providers communicate and work together to care for you.
- Submit bills to pay for your care.
- Help health care payors make sure services were actually provided.
- Help improve the quality of health care.
- Disclose information to certain officials or organizations where we may, or are, required to do so by law.

Every person who may access your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

Signature Date

Medical and Dental Health History:

1. Do you have or have you had any of the following? Please circle all that apply.

Artificial heart valve	Bleeding gums
Previous infective endocarditis	Red, swollen, or tender gums
Congenital heart disease	Gums pulling away from teeth
Heart transplant	Loose teeth
Heart disease	Separating teeth
Heart attack	Changes in your bite
Irregular heart beat	Bad Breath
Pacemaker	Prolonged bleeding
High blood pressure	Thyroid trouble
Chest pains or angina	Kidney disease
Stroke	Diabetes
Artificial joint	Asthma
Hepatitis or liver disease	HIV/AIDS
Tuberculosis	Radiation or cancer therapy

2. Do you have or have you had any disease, condition, or problem not listed? **NO** **YES**
3. Have you ever been hospitalized? **NO** **YES**
4. Have you had excessive or prolonged bleeding requiring special treatment? **NO** **YES**
5. Have you had an allergic reaction to any drugs or medications? **NO** **YES**
6. Are you currently under the care of a physician? **NO** **YES**
7. Are you pregnant or nursing? Estimated date of delivery ______________ **NO** **YES**
8. Do you smoke or use smokeless tobacco? **NO** **YES**
9. Have you had any trouble associated with previous dental treatment? **NO** **YES**
10. Do you have any lumps or sores in your mouth now? **NO** **YES**
11. How often do you have dental check ups? __________ Date of last exam __________
12. What concerns you most about your teeth? ________________________________
13. Why did you visit our office today? ________________________________
14. Are you satisfied with your smile? **NO** **YES**
15. Are you satisfied with the color of your teeth? **NO** **YES**
16. Do you have any missing teeth? **NO** **YES**
    If yes, would you like them replaced? **NO** **YES**

Please turn to page 6

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17. Do you have your wisdom teeth? **NO** **YES**
    If yes, have you been experiencing any discomfort with them? **NO** **YES**

18. Are you currently taking any drugs or medications? **NO** **YES**
    If yes, please fill in the section below

Current Medications:

Name	Dose / Frequency	Reason

I have reviewed the medical and dental health information I have provided, and to the best of my knowledge it is correct and complete.

Signature Date