Barrett L. Bartell, D.D.S., P.A.

Patient Information Form

This form was created to help our team learn more about you, your wishes and needs. Please read through and complete each section (Front and Back), as it pertains to you.

Dr. ☐ Mr.☐ Mrs. ☐ Ms. ☐ ____________ Marital Status   Child ☐ Male ☐ Female ☐   Date__________________

______________________________ Patient's Last Name   __________________________________ Patient's First Name   __________ Middle initial

Patient Prefers to be Called (Name and/or Title): ___________________________ Spouse Name________________

Birth Date: ____________Age: ______SS#_____________________ Driver's License #_____________________

Address: _________________________________ Street   _____________________ City   _________ State   ________________ Zip Code

(_____)______________________ Home Phone   (_____)____________________ Work Phone   (______)_________________________ Cell Phone

Do you prefer to be contacted by e-mail or phone?   ☐ E-mail   ☐ Phone

____ E-Mail Address for appointment reminders

___________________________(_______)________________ In the event of an emergency, who should we contact?

____ Who may we thank for referring you to our office?

____ Patient's Place of Employment or School Patient attends

Who is responsible for payment on the Patient's Account?
☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other (If Self, skip to next section.)

Responsible Party: ________________________ Last Name   __________________________ First Name   ____________ Middle Initial

Address: ______________________________ Street   ________________ City   ________________ Zip Code

(______)_______________________ Home Phone   (______)____________________ Work Phone   (______)___________________ Cell Phone

(Please complete other side of form)

Welcome To Our Practice

I UNDERSTAND MISSED OR BROKEN APPOINTMENTS WITHOUT A 24 HOUR ADVANCED NOTICE IS SUBJECT TO A $35.00 FEE. _________
Initial

WE DO NOT ACCEPT INSURANCE ASSIGNMENT. PAYMENT IS DUE ON THE DATE OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. AS A SERVICE TO YOU WE WILL BE HAPPY TO PUT YOUR INSURANCE INFORMATION INTO OUR COMPUTER SYSTEM AND GIVE YOU AN INSURANCE FORM FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

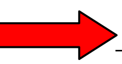
Name of Policyholder	Relationship to Patient	Policyholder Birth Date

Soc. Sec. # or Member #	Employer	Insurance Company	Group Number

Insurance Company Address	City	State	Zip Code

Insurance Phone Number (_______)___________________

AUTHORIZATION:
I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, the doctor and/or his staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and/or appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered at this office.



Signature of patient (or Guardian)	Date

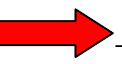
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

I acknowledge that I have read or can ask for a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that, withholding my signature means I have refused my consent for you to disclose my information to my insurance providers, payment providers and any other of my healthcare professionals.



Signature of Patient (or Guardian)	Relationship to Patient	Date

Barrett L. Bartell, D.D.S., P.A.

Medical History Form

Name: ____ Date: ________________

Address: ____

Phone: _____________________________ Sex: M F Date of Birth: ______________

For what reason have you come to our office: ____

In Case of Emergency Contact ___________________________ Phone No. _______________ Relationship ________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your health in the past year? .... Yes No
3. My last physical exam was on ______________________
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition? ____
5. The name of my physician is: ____
6. Have you had any serious illness, significant operation or hospitalization within the past *5* years? .... Yes No
   If Yes, List: ____
7. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies or diet pills?........ Yes No
   List medications and reasons: ____
   ____
8. Do you have or have you had any of the following diseases or problems:
   a. Damaged heart valves, artificial valves or heart murmur?.. Yes No
   b. Rheumatic Heart Disease?.. Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition? .... Yes No
      1. Chest pain upon exertion? .... Yes No
      2. Shortness of breath after mild exercise?.. Yes No
      3. Do your ankles swell?.. Yes No
   d. Glaucoma?.. Yes No
   e. Sinus trouble? .... Yes No
   f. Asthma? .... Yes No
   g. Fainting spells or seizures?.. Yes No
   h. Diabetes? .... Yes No
   i. Hepatitis, jaundice or liver disease? .... Yes No
   j. Frequent or recurring mouth sores?.. Yes No
   k. Thyroid problems?.. Yes No
   l. Respiratory problems, emphysema, bronchitis, etc? .... Yes No
   m. Arthritis or painful, swollen joints including jaw joint (TMJ)?.. Yes No
   n. Artificial Joint? If Yes, List ____ Yes No
   o. Stomach ulcer or hyperacidity? .... Yes No
   p. Kidney trouble? .... Yes No
   q. Tuberculosis?.. Yes No
   r. Persistent cough or cough that produces blood? .... Yes No
   s. Persistent swollen neck glands?.. Yes No
   t. Low blood pressure?.. Yes No
   u. Epilepsy or neurological disorder? .... Yes No
   v. Are you taking vitamins or homeopathic remedies?.. Yes No
   w. Cancer?.. Yes No
   x. Any disease, drug or transplant operation that has depressed your immune system?.. Yes No
      If yes, list ____

(Please complete other side of form)

9. a. Have you had abnormal bleeding? .... Yes No
If yes, when? ____________________
b. Have you ever required a blood transfusion? .... Yes No
If yes, when? ____________________
10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you ever had treatment for a tumor or growth? .... Yes No
12. Are you allergic to or have you had a reaction to:
a. Local anesthetics? .... Yes No
b. Penicillin or antibiotics? .... Yes No
c. Sulfa drugs? .... Yes No
d. Barbiturates or sleeping pills? .... Yes No
e. Aspirin? .... Yes No
f. Iodine? .... Yes No
g. Codeine or other narcotics? .... Yes No
h. Latex or rubber products? .... Yes No
i. Other? .... Yes No
13. Have you had any serious trouble associated with previous dental treatment? .... Yes No

If so, explain: ____________________

14. Do you have any other condition or disease you think the doctor should know about? .... Yes No

If so, explain: ____________________

15. Are you wearing contact lenses? .... Yes No
16. Are you wearing removable dental appliances? .... Yes No
17. Do you wish to talk with the doctor privately about anything? .... Yes No
18. Social History
a. Tobacco use .... Yes No
1. Cigarettes __________ Quantity__________ Years__________
2. Other__________ Quantity__________ Years__________
b. Alcohol Use .... Yes No
1. Amount per week__________
c. Recreational Drug Use .... Yes No

Women

19. Are you pregnant or trying to become pregnant? .... Yes No
20. Do you have problems associated with your menstrual period? .... Yes No
21. Are you nursing? .... Yes No
22. Are you taking birth control pills? .... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____________________ Patient's Signature: ____________________

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history:

____

____

Date: ____________________ Doctor's Signature: ____________________

Medical History Update:

Date	Comments	Signature

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentists of Barrett L. Bartell, D.D. S., P.A. and/or dental auxiliaries of his choice, to perform the following dental treatment including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids; as well as any of the following:

A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restorations, (fillings and crowns, root canal therapy).
D. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures, implants).
E. Removal (extraction) of one or more teeth.
F. Treatment of diseased or injured oral tissues (hard and/or soft).
G. Use of sedative drugs to control apprehension and or disruptive behavior.
H. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
I. Use of general anesthesia to accomplish the necessary treatment.

2. I understand that there are risks involved in all treatment and hereby acknowledge that these risks will be explained to me, and that I will have an opportunity to ask questions regarding the treatment and the risks of the treatment to be performed.
3. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nosepiece leaves an indentation or ring around the nose, which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
4. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip and cheek biting resulting in ulceration and in infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
5. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. The doctor (s) will discuss the additional treatment before proceeding with treatment. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.
6. I also authorize the doctors to use photographs, radiographs, and/or other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications.
7. I am advised, and agree, that the success of the dental treatment provided requires adherence to post-operative and post-care instructions provided by the doctor (s). I also agree that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
8. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment. I also understand that this consent will remain in effect until such time as I choose to terminate it.

Date: ________________________ Patient's Name Printed: ____

Name of Parent (or Guardian) if child: ____________________________Relationship to Patient: ______________

____ Signature: Patient or Parent/Guardian

____ Staff Signature as witness of consent

____ Doctor Signature

Barrett L. Bartell, D.D.S., P.A.

Financial Policies

Dr. Bartell, Dr. Howorth and all our staff are proud to provide you with top-quality care and are dedicated to making that care as cost effective as possible. Payment is expected at the time service is rendered, unless other financial arrangements have been made prior to the appointment. We accept cash, money orders, cashiers or personal checks, debit cards, Visa, MasterCard, Discover, and **CareCredit.**

We neither file insurance nor accept insurance benefits in lieu of your payment. Insurance is a contract between the patient, the employer and the insurance company and has no obligation to the dental office. Although we do not accept assignment of insurance benefits, as a service to you we are happy to provide the necessary forms for you to file on your insurance for reimbursement, and answer any questions you have about the process. In order for us best help you please give us all your pertinent insurance information so that we can provide accurate forms.

Because we truly want to make the financial aspect of your treatment as comfortable as possible, we want to introduce you to CareCredit, a flexible, interest free* and low interest* monthly payment plan that can be used immediately upon approval. Preapproval is available online at www.carecredit.com or our financial advisor can work with you in our office. * terms and conditions will apply

We are always available and willing to discuss these many payment options with you. Please don't hesitate to come to us with any questions you may have. We enjoy helping you and contributing to your successful treatment.

Barrett L. Bartell, D.D.S., P.A.

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 (04/01/03), 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 a 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, xrays, 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $50, for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. (Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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.

Restriction: 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.

Contact Office: Kim Bartell 6013 Wedgwood Drive Fort Worth, Texas 76133 (817) 346-6411