Bonnett Murphy Dental Associates

607 North Main Street
Butler, PA 16001

REGISTRATION AND TREATMENT FORM

Name_____
Last First Middle Initial

Address_____
Street City State Zip Code

Home Phone ( )_____Cell Phone( )_____

Work Phone ( )_____May we call your work number? Y_____N_____

Email_____Social Security#_____-_____-_____

Date of Birth_____/_____/_____Single_____Married_____Widowed_____Separated_____Divorced_____

Emergency Contact_____Phone( )_____

DENTAL INSURANCE INFORMATION

Insured_____Relationship to Insured_____

Social Security ID#_____Date of Birth_____/_____/_____

Insurance Company_____Phone( )_____

Group#_____Employer_____

SECONDARY DENTAL INSURANCE

Insured_____Relationship to Insured_____

Social Security ID#_____Date of Birth_____/_____/_____

Insurance Company_____Phone( )_____

Group#_____Employer_____

AUTHORIZATION

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand I am financially responsible for all charges and my balance regardless of insurance.

Signature_____Date_____

Bonnett/Murphy Dental Associates, PC

Eaglesoft Medical History

Patient Name:

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

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes	
Do you use controlled substances?	○ Yes ○ No	If yes	

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed	○ Yes ○ No	If yes	

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect 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:

X_____ Date:_____

CONSENT FOR TREATMENT

GENERAL CONSENT: In order to provide treatment for your dental needs it may be necessary to administer local anesthesia. The American Dental Association has recognized the anesthetic agents being used as being safe and effective when used in recommended dosages. The patient indicates understanding and wishes to proceed with treatment.

_____

Print name of patient

_____

Signature (patient, parent, or guardian)

Date_____

Richard Bonnett D.M.D.
Thomas Murphy D.M.D.
607 North Main Street
Butler, PA 16001
Phone: (724) 287-4468 fax: (724)287-3744

Financial Policy

Money problems seem to cause many misunderstandings between dental offices and patients. In this office we encourage brief discussions of our office charges and want you to feel free to discuss your financial questions with us.

Dental evaluations and treatment are covered by many dental insurance policies. Please check with your insurance company and/or employer to determine the amount and specifications of your policy's coverage.

Dr. Bonnett and Dr. Murphy participate with several dental plans. Please check with us to see if your insurance company is one which our Doctors participate with. Under these plans, your dental bill is submitted to your insurance company by our office and they are paid directly for the covered procedures. You are expected to pay for any procedures or services that are not covered, and for any deductibles and coinsurance percentages as required by your insurance company. If your insurance does not cover a procedure or you do not present your insurance information at the time of your visit, you will be responsible for the balance on the account. If we have not had a response from your insurance company within **90 days** of initial submission, the balance again will be your responsibility.

Your insurance carrier may not cover certain charges for treatment in our office. The responsibility for payment of these charges is your obligation. We try to simplify the preparation of insurance claims and thereby hold down the cost of your dental care. In order to do this, we ask that you be aware that your dental insurance may not cover the entire amount for the services rendered. A balance may remain on the account, in which monthly payment can be made at the discretion of the credit manager. Please feel free to inquire about any of our fees or payment policies.

For your convenience, cash, personal checks, debit cards, Visa, Master card, Discover, and American Express cards are all processed by our practice. Care Credit is also accepted as method of payment (with prior approval).

We have established and enforced certain financial procedures. We ask that our patients cooperated with the established policies.

I have read and understand the above policy:

Signed: _____ Date:_____

BONNETT MURPHY DENTAL ASSOCIATES – HIPAA PRIVACY POLICIES

Keeping your health information private is one of our important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. You have the right to discuss your concerns about how your health information is shared. The law under the Health Insurance Portability and Accountability Act (HIPAA) says:

1) We must keep your health information from others who do not need to know it.
2) We must make this notice available to you, and may only use and share your health information as explained in this notice.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your records to all health professionals who may provide treatment or who may be consulted by staff members.

Payments: Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying for services. An example would be your health plan may request and receive information on dates of service, services provided and medical conditions being treated.

Health Care Operations: Your health information may be used to support the daily activities of Bonnett Murphy Dental Associates. As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal: Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other Uses and Disclosures Requiring Authorization: Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information: Your health information will be used by our staff to contact you for appointment reminders. Your health information may be used to send you information on treatment and management of your medical condition. We may also send you information describing other health related products and services.

Individual Rights: You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to copy and inspect your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Bonnett Murphy Dental Associates Duties: We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices: We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in the federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information.

Request to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may access your records by contacting the office and speaking with the front desk personnel. Your request will be reviewed and will generally be approved unless there is legal or medical reason to deny the request.

Name_____

I wish to be contacted in the following manner:

Email:_____ Cell:_____

Home Number:_____ Okay to leave message:_____

Work:_____

Please list any person(s) that you allow this office to discuss your medical care with (such as parent, spouse, children, etc.)

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship:_____

I have been provided with the Notice of Information Practices. Prior to signing the consent, I have the right to review the Notice again, and if the facility changes the Notice , they must make the changes available to me. I have the right to question and ask that my health information not be utilized in a certain manner, although this facility may refuse my request in the mission of the delivery of quality healthcare services. I understand that I may change this consent in writing at any time.

THIS DISCLOUSURE WILL REMAIN IN EFFECT UNTIL NOTIFIED OTHERWISE BY THE UNDERSIGNED.

_____Date_____

(Patient or Guardian Signature)