Burton DENTISTRY

Burton Dentistry No Show/Cancellation Policy

EFFECTIVE 01/01/2021

Thank you for entrusting your dental care to Burton Dentistry!

We are dedicated to providing you with the best possible care in a friendly and efficient environment. In fostering this relationship, we have streamlined the appointment process to provide greater coordination of patient flow within our office. One of the foundations of the policy is an appointment reminder system. This system sends reminders at strategic time intervals before each appointment; therefore, we require patients to provide us with an E-mail address and a cell phone number to facilitate the reminders. Patients are also required to respond to the reminders, either by confirming or canceling their appointments as instructed, as we will no longer place courtesy reminder calls.

If you do not respond to the reminders, your appointment may be assigned to a patient on our waiting list. If you need to cancel your appointment, please provide a minimum of 48 hours (Office Hours Mon-Thurs/Not Fri-Sunday the office is closed and is not able to accept any cancellations). Our no show/cancellation fee is $50.00. A charge will be added to your account if 48 hours' notice is not given.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged.

Please provide the following information from your dental insurance card:

Patient's Name: _____ D.O.B:_____/_____/_____

Name of Policy Holder: _____ and Relationship _____

Patient's Social Security Number: _____-_____-_____

Policy Holder's Social Security Number: _____-_____-_____

Policy's Holder Employer: _____Dental INS Comp: _____

Group Number: _____Ins Provider Service# _____

Signature of patient (Parent or Guardian) _____ **Date:** _____

Burton DENTISTRY

PRACTICE GENERAL OFFICE POLICIES (PLEASE INITIAL ALL ITEMS BELOW): EFFECTIVE 1/1/2020

DENTAL RECORDS RELEASE: There is a $15.00 fee for researching, copying and mailing (if applicable), each dental record. The fee is due in full prior to their release. _____Initials

FINANCIAL: Your understanding of our financial policies is an essential element of your care and treatment. For your convenience we accept cash, checks (minimum $20.00), Visa, Discover and MasterCard. Full payment is due at time of service. **$50.00 returned check fee.** _____Initials

INSURANCE: We have made prior arrangements with many insurance plans. We will bill those plans with which we have an arrangement and will collect co-pays and/or deductibles at the time of service when you arrive for your appointment. In the event you're dental plan determines a service to be **Non-covered**, you will be responsible for the complete charge. Subsequently, we will bill you directly and payment is due upon receipt of the statement. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. . **We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.**

Authorization for Insurance Claims: I certify that I am covered by_____ insurance company and I assign directly to Dr. Burton all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. _____Initials

DIVORCE: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for subsequent charges. If the divorce decree requires the other parent to pay for the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. _____Initials

CANCELLATION: To avoid a cancellation fee of $50.00, please do the following:

Please respond to the reminders (sent by email/text), your appointment may be assigned to a patient on our waiting list if no response by 1 day before appointment. If you need to cancel your appointment, please provide a minimum of 48 hours (Office Hours Mon-Thurs/ ** Please note that the office is closed Fri -Sunday and is not able to accept any cancellations). Our no show/cancellation fee is $50.00 per 60 min appt. A charge will be added to your account if 48 hours' notice is not given.**

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged. _____Initials

I have read and understand the policies of the practice and I agree to be bound by the terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of patient (Parent or Guardian) _____ Print Name of Patient: (MINOR) _____Date: _____

Health History Form

Dr. Francesca M. Burton, D.D.S., P.C

ADA
American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last First Middle) | Home Phone: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: ( ) | Cell Phone: ( )
Include area codes

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Burton Dentistry, P.C.

Family & Cosmetic Dentist

Insurance Verification Form

Dear New Patient,

The Information you will provide will be kept confidential as per HIPPA regulations. As a service to our patients, we accept and file dental insurance. However, **YOU** are responsible for **ALL** communication with your insurance company except for additional information required of this office pertaining to specific procedures. Please understand that dent insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible which must be paid by the patient at the time of service. **We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care.**
Thank you for your cooperation!

Please provide the following information from your dental insurance card:

Patient's Name: _____ D.O.B:_____/_____/_____

Name of Policy Holder: _____

Relationship to Policy Holder: _____

Policy Holder's Social Security Number: _____-_____-_____ Policy's Holder D.O.B:____/____/____

Policy's Holder Employer Name: _____

Dental Insurance Company Name: _____

Group Number: _____

Insurance Company Phone Number: _____

Insurance Company Claims Address: _____

Authorization
I certify that I am covered by_____ insurance company and I assign directly to Dr._____ all insurance benefits otherwise payable to me. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____/_____/_____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
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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