Matthew Bentley DMD

2517 8TH AVE | FORT WORTH TX, 76110 | (817) 923-9877

NEW PATIENT INFORMATION

Patient's Name ______________________ Phone ______________ Cell ______________
Home Address __________________________ City ______________ ST ____ Zip______
Age__________ Gender____________ DOB_____/_____/______ SS#______________
Drivers License #______________ Email Address: ______________________
How did you hear about us? ______________________________________
Emergency Contact______________________________ Phone #______________
Relationship to Patient: ______________________________________

RESPONSIBLE PARTY & BILLING INFORMATION

Relation to Patient: Spouse _______ Parent _______ Other________
Name: ______________________________ DOB: ______ /_______ /________ Age: ________
Drivers License #______________ SS#: ______________________ Gender: ______________
Billing Address: __________________________ City ______________ ST______ ZIP______
Home Phone: ____________________ Cell: ____________________

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: ______________________ Insurance Co. Phone #: ______________
Group #______________ Insured's Employer: ______________________________
Insured's Name: ______________________ Patient Name: ______________________
Insured's Birthday: _____/______/_______ Insured's SS #/ID#: ______________________

SECONDARY INSURANCE

Insurance Co. Name: ______________________ Insurance Co. Phone #: ______________
Group #______________ Insured's Employer: ______________________________
Insured's Name: ______________________ Patient Name: ______________________
Insured's Birthday: _____/______/_______ Insured's SS #/ID#: ______________________

MEDICAL HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas that pertain to you.

Name of Physician ____________________________ Phone #______________________
Date of Last Visit _____/______/_______ your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Please explain: ______________________
____
Do you smoke? YES / NO Packs per Day? ______ Number of Years? ________
Please list ALL medications you are now taking (include over the counter drugs and vitamins):
____
____

Do you need antibiotic premedication before dental treatment? YES / NO If yes, please explain what you take and why:
____
Are you currently taking Coumadin or any other Blood Thinner? YES / NO
We will need a release from your Doctor before dental treatment can be done? YES / NO

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If Female, are you: Pregnant ______ Nursing _____ Taking Birth Control Pills _____

Please circle any of the following medications you are ALLERGIC to:

- Valium
- Lortab
- Latex
- Versed
- Penicillin
- Aspirin
- Codeine
- Vicodin
- Keflex
- Doxycycline
- Erythromycin
- Tylenol
- Sulfa Drugs
- Demoral
- Dental Anesthetics
- Halcion

List any other medications you are allergic to:

____

____

Please circle any of the following that you now have or have ever had:

AIDS/HIV	Epilepsy/Seizures	Lesions
Anemia	Fainting/Dizziness	Liver Disease
Angina/Chest Pain/Shortness of Breath	Frequent Headaches	Low Blood Pressure
Arthritis/Rheumatism	Heart Attack	Psychiatric Care
Artificial joints	Heart Murmur	Rheumatic Fever
Asthma	Heart Trouble	Sickle Cell Disease
Blood Transfusion	Hemophilia	Sinus Trouble
Cancer	Hepatitis	Stroke
Congenital Heart	High Blood Pressure	Thyroid Disease
Diabetes	Kidney/Bladder Trouble	Ulcers

Do you have any medical conditions not listed above that we should know about? Please list below.

____

____

DENTAL HISTORY

Previous Dentist ___________________________ City ______________________ ST___ ZIP______

Date of Last Cleaning ______/_______/_______Frequency of Cleanings __________________

Do you brush your teeth daily _____Manual / Mechanical Brush (circle) **Do you floss daily?** Yes / No

Reason for your visit today? ____

____

Do You Want to Keep Your Teeth? (Check one)

_____ Yes, no matter what it takes / _____ I Don't Know /

_____ Yes, if it is not too much trouble / _____ I Don't Care

Are your happy with your smile? ______ Yes ______ No

If not, what would you change?

____

Please circle any of the following that you now have or have ever had:

Mouth Discomfort	Previous Periodontal Treatment	Gum Abscesses
Scaling/Root Planning	Bleeding Gums	Orthodontic Treatment
Cold Sores or Fever Blisters	Mouth Odor or Bad Taste	Gum Surgery
Loose or Shifting Teeth	Other Oral Lesions/Sores	Sensitive Teeth (Hot, Cold, or Sweets)
Snoring	Stop breathing when you sleep	Do you wake up gasping for air
Bad Breath	Dry mouth when you wake	Headaches upon waking
Grinding or Clenching Your Teeth	Clicking, Popping or Pain in jaw	Sore or tender jaw muscle
Worn down teeth		

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CONSENT

- I authorize the Doctor or his representatives to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper recommendations for (name of patient) ____'s treatment.
- I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy indicated after all my questions have been answered.
- Scheduling an appointment is interpreted as authorization for treatment. I also understand that the use of anesthetic agents embody certain risks.

Patient/Parent/Guardian Signature: ________________________________ Date: ____________________

Written Financial Policy

Thank you for choosing Matthew Bentley DMD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. **Payment Options:** - Cash, Check, Visa, MasterCard, American Express or Discover Card. We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $500 or more. Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card **Allow you to pay overtime AND No annual fees or pre-payment penalties**

Please note:

Matthew Bentley DMD requires payment prior to the completion of your treatment. For plans requiring more than 2 appointments, alternative payment arrangements may be provided.

For INVISALIGN, a $1500.00 deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

We know your time is important, but so is ours. Keep in mind that when we schedule an appointment for you, we reserve that time JUST FOR YOU! We want to give you our individual attention. Please give us the courtesy of at least 48 hours notice if you need to change or cancel your appointment. Thank you.

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Confirmation of Appointment

To ensure reservation of your appointment time please indicate how you would like to be contacted to confirm your visit? **Please check all the apply**

______ Phone Call
______Text
______Email
______ All of the above

Matthew Bentley DMD charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

____
Patient, Parent or Guardian Signature Date

____
Patient Name (Please Print)

[1]Subject to credit approval[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____
____
____

________________________________ ________________
Employee signature *Date*

BENTLEY DENTAL ♦ 2517 8TH Avenue, Fort Worth, TX 76110 ♦ 817.923.9877

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:

Patient's Date of Birth: Patient's SSN:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations.** Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

____ ________________
Patient's Signature or Signature of Patient's Representative Date

____ ________________
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Matthew R. Bentley, D.M.D.

Practice Address: 2517 8th Avenue, Fort Worth, TX 76110

Phone: 817.923.9877 Fax: 817.923.9854 E-Mail: bentleydentalfwtx@gmail.com

Dr. Matthew Bentley, D.M.D.

Cosmetic ■ Family Dentistry ■ Invisalign ■ Sleep Apnea Appliances

Communication Consent

Date____________________

I, ________________________________ want Bentley Dental to communicate with me via e-mail, phone, text, or mail about services that pertain to my conditions or that can contribute to matters related to my health and/or dental treatment. I understand my Protected Health Information may be referenced to determine that I may be likely candidate for products or services that my dental health practitioner may share with me. Bentley Dental may communicate with me about my oral health, treatment, appointments, and post –operative follow-ups by e-mail, text, or by phone. It is my responsibility to ensure all my contact information is up to date.

I understand that communication between Bentley Dental and I may not be encrypted and my information could be intercepted by unauthorized persons. I agree to hold Bentley Dental harmless for any actions resulting from intercepted communications.

Bentley Dental will not be responsible for any unauthorized interceptions. However, we will make reasonable measures to ensure proper delivery or notification of out patient's information. Examples include, but not limited to post –operative phone calls, and appointment reminders.

This consent remains in effect until expressly revoked in writing.

Name: ___________________________________

Signature: ____

Witnessed by: ____

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on11/01/2014 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Matthew R. Bentley, D.M.D.. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
(a) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your health information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $_____for each page and the staff time charged will be $_____per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.
(b) Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your PHI and ePHI to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when

requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get electronic copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $_____ per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to request and receive an accounting of certain non-routine disclosures of your identifiable health information. We are required to maintain a log of these non-routine disclosures for a period of no less than six years beginning April 14, 2003. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name: **BENTLEY DENTAL** Privacy Officer: **Matthew R. Bentley, D.M.D.**

Telephone: **817.923.9877** Fax: **817.923.9854**

Address: **2517 8th Avenue, Fort Worth, TX 76110**

Email: **bentleydentalfwtx@gmail.com**