BARKSDALE DENTISTRY
JOHN BARKSDALE, D.D.S.
family dentist

Patient Information

Date:_____ SSN:_____

Patient Name: _____
Last Name

_____
First Name Middle Initial

Address:_____

_____

City:_____ State: _____ Zip:_____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

☐ Married ☐Widowed ☐Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Patient's Employer/School: _____

Occupation: _____

Employer/School Address:_____

_____

Who may we thank for referring you?

_____

Contact Information

Please check your primary phone number:

☒ Home ( ) _____

☐ Work ( ) _____ ext _____

☐ Cell ( ) _____

Would you like to receive communications though text messages? ☐ Y ☐ N

Email: _____

Would you like to receive communications though Email? ☐ Y ☐ N

What is the best time to contact you? _____

Emergency Contact

In the case of an emergency, who can we contact?
(Specify someone who does not live in your household).

Name: _____

Relationship: _____

Home ( ) _____

Work ( ) _____ ext _____

Cell ( ) _____

Insurance and Financial Information

Who is responsible for this account? _____

Relationship to Patient: _____

Dental Insurance Company: _____

Subscriber's Name: _____

Group # _____ Subscriber's Birthdate: _____

Subscriber's ID/SSN: _____

Relationship to Patient: _____

Is this patient covered by additional insurance? ☐ Y ☐ N

Dental Insurance Company: _____

Subscriber's Name: _____

Group # _____ Subscriber's Birthdate: _____

Subscriber's ID/SSN: _____

Relationship to Patient: _____

Is this patient covered by Medical Insurance? ☐ Y ☐ N

Medical Insurance Company: _____

Subscriber's Name: _____

Group # _____ Subscriber's Birthdate: _____

Subscriber's ID/SSN: _____

Relationship to Patient: _____

Assignment and Release

I certify that I, and/or my dependents have insurance coverage with the listed insurances above and assign directly to Barksdale Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of all my signatures on all insurance submissions.

Barksdale Dentistry may use my healthcare information and may disclose such information to the above names Insurance companies and the agents for the purpose of obtaining payments for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient/Parent/Guardian/Personal Representative

_____
Print Name of Patient/Parent/Guardian/Personal Representative

_____ _____
Date Relationship to Patient

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No			
			Lip or cheek biting	☐ Yes	☐ No	How often do you floss? _____		
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

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Health History

Physician's Name: _____ Date of last Visit: _____

Have you ever taken any group of drugs collectively known as "fen-phen?" These include combination of Ionmin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV	☐	**Yes**	☐	**No**
Anemia	☐	Yes	☐	No
Arthritis, Rheumatism	☐	Yes	☐	No
Artificial Heart Valves	☐	Yes	☐	No
Artificial Joints	☐	Yes	☐	No
Asthma	☐	Yes	☐	No
Back Problems	☐	Yes	☐	No
Bleeding abnormally, with extractions or surgery	☐	Yes	☐	No
Blood Disease	☐	Yes	☐	No
Cancer	☐	Yes	☐	No
Chemical Dependency	☐	Yes	☐	No
Chemotherapy	☐	Yes	☐	No
Circulatory Problems	☐	Yes	☐	No
Congenital Heart Lesions	☐	Yes	☐	No
Cortisone Treatment	☐	Yes	☐	No
Cough, persistent or bloody	☐	Yes	☐	No
Diabetes	☐	Yes	☐	No

Epilepsy	☐	**Yes**	☐	**No**
Fainting or Dizziness	☐	Yes	☐	No
Glaucoma	☐	Yes	☐	No
Headaches	☐	Yes	☐	No
Heart Murmur	☐	Yes	☐	No
Heart Problems	☐	Yes	☐	No
Hepatitis Type: _____	☐	Yes	☐	No
Herpes	☐	Yes	☐	No
High Blood Pressure	☐	Yes	☐	No
Jaundice	☐	Yes	☐	No
Jaw Pain	☐	Yes	☐	No
Kidney Disease	☐	Yes	☐	No
Liver Disease	☐	Yes	☐	No
Low Blood Pressure	☐	Yes	☐	No
Mitral Valve Prolapse	☐	Yes	☐	No
Nervous Problems	☐	Yes	☐	No
Osteoporosis	☐	Yes	☐	No
Psychiatric Care	☐	Yes	☐	No

Radiation Treatment	☐	**Yes**	☐	**No**
Respiratory Disease	☐	Yes	☐	No
Rheumatic Fever	☐	Yes	☐	No
Scarlet Fever	☐	Yes	☐	No
Shortness of Breath	☐	Yes	☐	No
Sinus Trouble	☐	Yes	☐	No
Skin Rash	☐	Yes	☐	No
Special Diet	☐	Yes	☐	No
Stroke	☐	Yes	☐	No
Swollen Feet or Ankles	☐	Yes	☐	No
Swollen Neck Glands	☐	Yes	☐	No
Thyroid Problems	☐	Yes	☐	No
Tonsilitis	☐	Yes	☐	No
Tuberculosis	☐	Yes	☐	No
Tumor or Growth on head/Neck	☐	Yes	☐	No
Ulcer	☐	Yes	☐	No
Venereal Disease	☐	Yes	☐	No
Weight loss, unexplained	☐	Yes	☐	No

Do you or have you taken medication collectively known as bisphosphonates? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No

Taking Birth Control pills? ☐ Yes ☐ No

Medication

List any medications you are currently taking and the correlating diagnosis: _____

_____

_____

_____

Pharmacy Name: _____

Intersection: _____

Phone ( )_____

Allergies

Please check that applies:

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ No known Drug Allergies
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other: _____
_____

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Consent for Dental Treatment and Acknowledgement of Receipt of Information

State Law requires us to obtain your consent for dental treatment. Please do not hesitate to ask us to explain anything to you that you may not understand before treatment is rendered. This is a general consent for treatment form. All of your options and a thorough explanation of the procedures will be given to you.

I understand dentistry is not an exact science and complications may occur despite our best efforts. There are risks associated with any dental treatment. This includes the administration of any local or general anesthetic agent, analgesic agent(s) to produce conscious sedation, and/or pre-medication prior to dental care being rendered. Some of these risks/complications are, but are not limited to, the following:

- Sensitivity to temperature (hot/cold)
- Damage, fracture or possible loss of the tooth/teeth being treated as well as adjacent teeth and bone
- Failure of wound to heal
- Injuries to adjacent teeth and/or soft tissue
- Paresthesia or numbness of: tongue, and/or mouth, and/or face
- Fracture of mandible (upper jaw) or maxilla (lower jaw)
- Opening between mouth and sinus or mouth and nose
- Slough (unanticipated loss of hard and/or soft tissue)
- Swallowing and/or aspiration of prosthesis and other objects
- Trismus (jaw pain or difficulty opening mouth)
- Additional surgery, hospitalization and/or further treatment may be required in the event of any complication(s)
- Burns from chemical agents used in treatment or dental treatments
- Loss of or damage to the ability to taste, speak, hear and/or see
- Breakage or root(s) and retained root fragments
- Damage to or possible loss of filings or other dental work
- Change in bite
- Incomplete removal of tooth
- Loss of tooth/teeth or loss of bone
- Dry socket
- Injury to adjacent structures
- Instrument breakage
- Allergic reaction to drugs
- Bacterial Endocarditis
- Failure or treatment to accomplish its purpose
- TMJ Dysfunction or worsening of TMJ condition
- Injury from airborne particles or instruments
- Infection
- Bleeding
- Tooth or fragment in maxiallary sinus

State Law also requires that I specifically advise you, although rarely occurring, the dental treatment or anesthetic may result in: Paraplegia (paralysis of both legs); Quadriplegia (paralysis of both arms and legs); Loss or loss of function of an organ(s) or limb(s); Brain Damage; or Death.

Acknowledgment

I acknowledge that I have read, or that it has been read to me, and I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked, were answered to my satisfaction. I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid until revoked by me in writing.

_____ _____

Signature of Patient or Guardian **Date**

BARKSDALE DENTISTRY
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FINANCIAL ARRANGEMENT POLICY

Payment for services is due in full at the time services are rendered unless prior arrangements are made with our office. Any account balance 90 days old or greater may be subject to interest charges, delinquent billing fees, collection fees, attorney fees, and/or court cost. If your scheduled appointment time for treatment is 1 ½ hours or greater, a 50% deposit towards your portion due is required at the time the appointment is scheduled. We accept cash, credit card, and check payment. Should a check return due to Non-Sufficient Fund, our office will bill you for the original amount and an additional $35 bank fee.

_____ _____

Signature of patient, parent, or responsible party **Date**

SCHEDULING POLICY

To offer quality care to all of our patients, you are seen by appointment. By doing this, we may be ready and able to see you in a timely manner. We strive for prompt service so that you will not be left waiting. Therefore, we ask that you ARRIVE ON TIME for your appointment. Due to the volume of patients needing our care we also ask, should a change in your schedule occur you call to reschedule at least 24 HOURS prior to your appointment. If proper notice is not given, this will result in a $50.00 MISSED APPOINTMENT FEE for each hour scheduled. As a courtesy, we will call you prior to your appointment as a reminder. We thank you for your cooperation.

_____ _____

Signature of patient, parent, or responsible party **Date**

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Insurance Notice to Our Patients

You have indicated to us that you have dental insurance. As a courtesy to you, we will submit your services and wait for payment. You are responsible for monitoring the use of your benefits and remaining within your maximum covered benefit during each year of coverage.

However, when we go over treatment plans with you, this is only an estimate from the percentages given to us by your insurance company. The deductible and estimated percentage that your insurance company does not cover is to be paid upon the date of service.

When you pay your estimated portion, this does not always mean that you have paid your final payment towards these services. If your insurance company does not pay the entire estimated amount, you are left responsible to pay any remaining balance. Please note that our fees are not based on any insurance schedules, and may be above insurance allowances. We do not accept downgraded fees or insurance code changes.

By signing this form, I understand these terms.

_____ _____
Patient Name Date

_____ _____
Signature of Patient, Parent, or Responsible Party Date

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NOTICE OF PRIVACY PRACTICES

I understand that my healthcare information concerning my diagnosis, treatment, payment, and insurance will be disclosed when necessary for filing insurance, and in communication with other health professionals in the course of my treatment or their offices. Limited information will also be disclosed to business supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services, and consultants. These businesses are restricted in the use and disclosure of your information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.

I understand that my files are stored on shelves in the business office. Only staff and janitorial personnel may have access to this office during non business hours. I understand that this office will make every effort to keep you information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy, or inspect and correct my healthcare information, the right to restrict disclosures and obtain an accounting of disclosures. I have the right to voice my concern about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. (A minimal fee will be charged to me for copies of records that I request)

I understand that I will receive communication in the form of phone calls and/or postcards to remind me of an existing appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mails or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voice mail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims, and health care operations. This office retains the right to revise the privacy policy.

_____ _____

Patient Signature **Date**

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Designation of Personal Representative

Please use this form to designate a personal representative to act on the behalf of the patient below, in making health care-related decisions, and to have unlimited access to the patient's information. The patient named below is signing this designation and consenting to the release of information. If the patient is a minor, a parent or legal guardian must sign. If the patient is unable to sign for any other reason, a legal representative must sign the designation and submit documentation to verify the authority to sign.

Patient's Name _____ Date of Birth _____
Address _____
Home Ph ( ) _____ Work Ph ( ) _____ Cell Ph ( ) _____
I hereby designate the following individual(s) as my personal representative:
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Please read each of the following statements carefully before signing this document.

● I understand that this designation will not expire unless I indicate an expiration date or I revoke it. Date to expire: _____ (if indicated)

● I understand that this designation is voluntary and being made at my request.

● I understand that the released information may no longer be protected by federal privacy laws and may be redisclosed by the individual that receives the information.

● I understand that I may revoke this Designation of Personal Representative at any time by sending a written notification to Barksdale Dentistry, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that my health plan has already used or disclosed, relying on this designation. I may receive a copy of this designation and agree that a photocopy is as valid as the original.

Print Name _____ Date _____

Signature _____ Relationship to patient _____

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Photography Release

I, _____,hereby authorize Dr. _____or his/her assistants to take photographs, slides, and/or videos of my face, jaws, mouth, and teeth.

I understand that the x-rays, photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines).

I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature _____

Date _____

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COVID-19 PANDEMIC DENTAL TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK

The World Health Organization has characterized the COVID-19 virus, also known as "Coronavirus," as a pandemic. Our practice wants to ensure you are aware of the risks of exposure to COVID-19 associated with receiving treatment during this pandemic.

COVID-19 is highly contagious and has a long incubation period. You or your healthcare providers may have the virus, not show symptoms and yet still be highly contagious. COVID-19 can result in a life-threatening respiratory disease in some patients. You may be exposed to COVID-19 at any time or in any place. Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures can create fine water spray or "aerosols" which may remain in the air for several minutes to hours. These aerosols may contain the COVID-19 virus and may create a risk of COVID-19 exposure. You cannot wear a protective mask over your mouth to reduce exposure during treatment as your healthcare providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

To provide a safe environment for our patients and staff, this practice follows the applicable state and federal regulations and protocols for infection control, universal personal protection, and disinfection. However, due to the nature of the procedures we provide, it may not be possible to maintain social distancing between patients, doctors, and staff at all times.

Patient Acknowledgement

I acknowledge that I have read the Notice above and that I understand and accept that there is an increased risk of COVID-19 exposure with treatment during the pandemic.

I understand and accept the increased risk of COVID-19 exposure with treatment at this office.

I also acknowledge that I could, or may have, exposure to COVID-19 from outside this office and unrelated to my visit here.

I have read and understand the information stated above:

_____ _____
Patient or Legal Representative Signature Date

_____
Print Patient or Legal Representative Name/Relationship

_____ _____
Witness Signature (optional) Date

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COVID-19 Pandemic - Patient Disclosures

This patient disclosure forms seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for Covid-19?	☐	☐
Have you tested for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus, or train within the last 14 days?	☐	☐

I fully understand and acknowledge the above information, risks, and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Print Name Date

_____ _____

Signature Witness