Registration

Patient full name: ____Name you wish to be called: ____________

Sex: Male Female E-mail address: ____

Mailing address: ____

Phone: Home: ____________________Work: ____________________Cell: ______________________

Date of birth: _______________Social security #: ________________Driver's license #: ____________

Student status: Full time Part time Not a student

Employee status: Full time Part time Retired Not employed

If employed: Employed by _____________________________________How long: _________

Present position: ____

Marital status: Single Divorced Widowed Separated Married

If married: Spouse's full name ____

Emergency contact: Name: ___________________________ Phone: ___________________________

If an adult, who may we share your health information and appointments with?

____

Is patient responsible for payment of this account? Yes No

If patient is not responsible for payment, who is? ____

What is the relationship of the responsible party to the patient? _________________________________

Address: ____

Phone: Home: ____________________Work: ____________________Cell: ______________________

Birth date: _______________Social security #: ________________Driver's license #: ______________

Employed by: ____How long: ________________

Present position: ____

If responsible party is married to someone other than patient:

Spouse's name ____

Spouse's address: ____

Spouse's phone: Home: _________________Work: __________________Cell: __________________

Spouse's birth date: _______________Spouse's social security #: ______________________________

Spouse employed by: ______________________________________How long: ________________

Present position: ____

Signature: ____ **Date:** ______________

Please check one: ( ) Adult patient ( ) Parent or Guardian ( ) Spouse

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

Do you have dental insurance?: Yes No If yes, please fill out information on the next page.

Office use only: Entered into computer: ____ Date: ________ Scanned into computer: ____ Date: ________

Dental Insurance

Full name: ____

If you have a dental insurance policy:

Responsible party's primary dental insurance policy:

Employee's name: ____Birth date: __________________

Employee's address: ____

Employee's phone: Home: ________________Work: _______________Cell: __________________

Employee I D #: _________________________Social security #: ____________________________

Employer's name: ____

Employer's address: ____

Employer's phone: ____

Group policy name: ______________________Group or union local number: ____________________

Plan type: Indemnity PPO DMO Retired Salary Hourly Other: ______________________

Insurance carrier: ____

Carrier address: ____

Carrier phone: ____

If you have a second insurance policy:

Responsible party's secondary dental insurance policy:

Employee's name: ____Birth date: __________________

Employee's address: ____

Employee's phone: Home: ________________Work: _______________Cell: __________________

Employee I D #: _________________________Social security #: ____________________________

Employer's name: ____

Employer's address: ____

Employer's phone: ____

Group policy name: ______________________Group or union local number: ____________________

Plan type: Indemnity PPO DMO Retired Salary Hourly Other: ______________________

Insurance carrier: ____

Carrier address: ____

Carrier phone: ____

Office use only: Entered into computer: ____ Date: ________ Scanned into computer: ____ Date: ________

Medical History

Name: ______________________________________

Do you have or have you had any of the following conditions? (Circle Y or N)

Y N Prosthetic joint
Y N Heart artificial valve
Y N Heart transplant
Y N Heart infection
Y N Heart defect at birth
Y N Heart surgery
Y N Heart attack
Y N Artery stent
Y N Stroke
Y N High blood pressure
Y N Low blood pressure
Y N Jewelry allergy
Y N Latex allergy
Y N Penicillin allergy
Y N Amoxicillin allergy
Y N Sulfa allergy
Y N Codeine allergy
Y N Hodrocodone allergy
Y N Pacemaker
Y N Defibrillator
Y N Hepatitis or liver problems
Y N Diabetes
Y N Epilepsy
Y N Kidney problems
Y N Arthritis
Y N Hemophilia
Y N Anemia
Y N Mononucleosis
Y N Herpes
Y N AIDS
Y N HIV positive
Y N Venereal disease
Y N Sinus trouble
Y N Asthma
Y N Emphysema
Y N Tuberculosis
Y N Cancer
Y N Leukemia
Y N Chemo treatment
Y N Radiation treatment
Y N Thyroid problems
Y N Severe headaches
Y N Alzheimer's disease
Y N Dementia
Y N Nervous problems
Y N Bladder problems
Y N Prolonged bleeding
Y N Glaucoma
Y N Chew tobacco
Y N Smoke
Y N Drink alcohol
Y N Pregnant
Y N Other allergies (please list if yes):____
Y N Do you require antibiotics before dental treatment due to heart problems or joint replacement?
Y N Have you ever taken a bisphosphonate for osteoporosis or bone cancer? (Fosamax, Actonel, Aredia, Zometa, Ostac, Benefos, Bidronel, Alvista, Forteo, Skelid, Boniva, etc.)

Please list any medications that you take or provide separate list: ____

____

Physician's name, city, and phone: ____

Pharmacy name and phone: ____

Serious illnesses, operations, and other medical conditions: ____

____

I give consent to John R Burnett, III, DDS and his staff to perform any necessary services needed during diagnosis and treatment. In accord with Texas state law (108.7), stating that consent is required for all treatment plans and procedures where a reasonable possibility of complications from the treatment planned or a procedure exists and such consent should disclose risks or hazards that could influence a reasonable person in making a decision to give or withhold consent. I authorize John R Burnett, III, DDS to release any information required to verify insurance and process insurance claims.
I agree to the release all photographs and x-rays for use in teaching, education, and publication.
If 18 or older I give permission to discuss financial concerns with the guarantor.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
I have received a copy of "Notice of Privacy Practices".

Signature: ____ **Date:** ________________
Please check one: ( ) Adult patient ( ) Parent or Guardian ( ) Spouse

Office use only: Entered into computer: ____ Date: ________ Scanned into computer: ____ Date: ________
Medical history review: ____ year old (male or female) has a medical history that is of ____________________________
______________________________ (or non-contributory). ASA____. _________________________ Date: ________

John R Burnett, III, DDS, MAGD

3413 BROADWAY, GARLAND, TX 75043 972 271 8585

Financial Policy

Thank you for choosing us to provide your dental care. 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 - you may choose from:

- Cash, Check, Visa, MasterCard, American Express, Discover Card, or Debit Cards
- CareCredit with no interest[1] payment plans[2]
- Dental Insurance to pay a portion of costs, patient pays in advance an estimated balance
- Two Equal Payments for treatment plans that are over $500 and require two appointments
- Three Equal Payments for treatment plans that are over $1000 and require three or more appointments

The details:

* Payment is required prior to the completion of your treatment.
* We offer a 5% courtesy accounting adjustment to patients who pay for their entire treatment with cash or check prior to starting treatment for treatment plans of $1000 or more.
* CareCredit allows you to pay over time with no interest[1], offers convenient, low monthly payment plans[2] and has no annual fees or pre-payment penalties.
* For treatment plans over $500 and requiring two appointments we will accept two equal payments. 1st payment – before treatment starts and final payment at final appointment.
* For treatment plans over $1000 and requiring three or more appointments we will accept three equal payments. 1st payment – before treatment starts, 2nd payment – middle appointment, and final payment before final appointment.
* If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
* There is a $25 charge for all returned checks.
* It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, you are encouraged to contact us promptly for assistance in the management of your account.
* In order to charge on an existing overdue account, either the overdue amount must be paid in full or the charges must be paid at time of service.
* Unpaid balances that are greater than 30 days will begin incurring interest charges at an annual percentage rate (APR) of 15%. Collection charges are also added to your account to be paid.
* CareCredit: [1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2]Subject to credit approval.

If you have any questions regarding the above information, please do not hesitate to ask.

This form must be signed prior to services rendered. It will become a part of your permanent record with this office. Thank you. I have read the above and agree to this financial policy.

Signature____Date__________________________

Office use only: Entered into computer: ____ Date: ________ Scanned into computer: ____ Date: ________

John R Burnett, III, DDS, MAGD

3413 BROADWAY, GARLAND, TX 75043 972 271 8585

Dental Insurance Facts

Dental insurance plays a large role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, and in an effort to maintain the high quality of dental care, we would like to share with you **some dental insurance facts:**

- As a courtesy to you we will fill out and submit insurance forms for you at no charge.
- We will do all we can to assist you in obtaining your maximum benefits.
- We will gladly try to answer questions regarding your insurance coverage.
- We must emphasize that, as your dentist, my relationship is with you, not your insurance company.
- Your insurance policy is a contract between you, your employer, and your insurance company. **Please understand Dr Burnett is not a party to that contract and has no control over your insurance company.**
- We are able to provide dental services for all indemnity dental insurance plans.
- We are able to provide dental services "out of network" for all PPO dental insurance plans. **Please understand Dr Burnett is not "in network" with, is not "on" any PPO plan and does not wish to be as this could decrease the quality of dentistry he strives to provide.**
- We are not able to provide dental services for HMO dental insurance plans as they only pay "in network" Doctors. **Please understand Dr Burnett is not "in network" with, is not "on" any HMO plan and does not wish to be as this could decrease the quality of dentistry he strives to provide.**
- Due to insurance companies taking so much longer than they used to in paying their portion, we find it necessary to collect the approximate patient's portion of the cost of dental care at the time of service. This will usually include the deductible, 30% of basic work, and 60% of major work.
- After the insurance company pays what they will pay, the patient will be billed for the balance, if any. Unpaid balances begin incurring interest charges after 30 days.
- If the insurance company does not pay, for whatever reason, within 90 days of the date of service, the patient will be responsible for the balance and interest charges will start to accrue.
- Not all dental services are covered benefits in your contract. Some insurance companies arbitrarily select certain services they will not cover and these charges are the patient's responsibility. These are sometimes very basic services that most other policies do cover. It is not unusual to have above average coverage on some procedures and below average coverage on other procedures, all within the same policy. Your dental needs are not always what your policy can afford.
- Fees for these services that your insurance policy does not cover are due at time of service.

- Insurance companies are not primarily in the business to help you. They are in the business to make money for their stockholders.

- No dental insurance is meant to be a "pay all" policy. It is meant only to be an aid to the overall expense of dental care.

- You may receive a letter from your insurance company stating that dental fees are higher than the "usual, customary, and reasonable" rate, or "UCR". To determine the UCR, an insurance company survey's a geographic area, usually uses data that is one to three years old, finds the average fee, and then discounts those fees between 10-30% and considers that lowered fee to be the UCR. Therefore, any doctor in private practice will have fees that are considered "higher than average".

- Considering the above information**, there is no such thing as a "usual, customary, and reasonable" fee** and its use by dental insurance companies is misleading to the public. It is actually a "maximum plan allowance", which is in direct proportion with what your employer pays for your dental insurance policy. In other words: A higher cost policy pays a better fee.

- Many insurance plans tell their insured that they will be covered "up to 80% or 100%", but do not clearly specify that there are "fee schedule allowances", "annual maximums", and "limitations". We've found that most plans cover about 70% of basic services and 35% of major services after taking the above into consideration.

- **A pre-determination is not a guarantee** that the insurance company will cover all of the services pre-determined. It is sometimes very inaccurate and often misleading. The insurance company loves for you to want a pre-determination, because they know that you are putting off the needed dental work and it saves them money. They also know that you sometimes forget to have the dental work done at all after delaying it.

- Insurance companies will use a variety of **tactics to delay payment**. They very often would request x-rays as a delay tactic, but as dental offices became wise and started enclosing them, new tactics developed. A most common tactic is telling us they "never received the claim", but this happens so often that it seems very suspicious. Now they are changing their post office boxes so that claims are "returned to sender" and we are left with trying to track down the "post office box of the month".

If you have any questions regarding your insurance, we ask that you contact your insurance company about the specifics and details of the plan it is conducting in your behalf.

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 your 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 4/14/2003, 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 to 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 at the end of this Notice.

USES AND DISCLOSURES AND HEALTH INFORMATION

We use and disclose 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, x-rays, 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 $1.00 for each page, $25.00 per hour 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 for treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 4/14/2003. 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 call 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 may also 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 Resources 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 Sources. Contact: John R Burnett, III, DDS, MAGD, Attn: Phyllis, 3413 Broadway, Garland, TX 75043, 972-271-8585.