L. "Randy" Buntyn, D.M.D.

Implant, Cosmetic & General Dentistry

-Your General Information-

First Name _____ Last Name _____ Preferred_____

Address _____City _____State _____ Zip_____

Birthday _____ Age _____ Social Security # _____

□ Male □ Female Marital Status: ___Married ____Single ____Divorced ____Other

Full Time Student □ Yes □ No School Name_____

Employer _____ Occupation_____

Previous Dentist _____ Previous Dentist Phone_____

Date of Last Visit _____

How did you hear about us?_____

-Your Contact Information-

Phone Numbers:

Home _____Cell _____Work _____

E-mail _____

We would like to make communication convenient and helpful. We have the ability to communicate with you through text messaging and e-mail for appointment reminders. Please check below to indicate the types of communications you would like to receive. Your information will not be shared and you will not receive junk e-mail as a result of sharing your information with us.

____ Personal Phone Calls ____Text Messages ____E-mail

Emergency Contact:

Name_____Relationship_____

Phone #1_____Phone #2_____

-Your Dental History-

Why have you come to the dentist today?

_____

_____

Have you been advised to take antibiotics before dental treatment?.....YES___ NO___
If YES, please list reason and by whom _____
Do your gums bleed when you floss or brush?.....YES___ NO___
Do you floss on a regular basis?..... YES___ NO___
Is your mouth dry?..... YES___ NO___
Have you had periodontal (gum) treatments?..... YES ___ NO ___
Have you ever had orthodontics (braces) treatment?..... YES ___ NO ___
If YES, please list years and Doctor/ Clinic _____
Are you currently experiencing dental pain or discomfort?.....YES ___ NO___
Do you have earaches or neck pain?..... YES ___ NO ___
Do you have any clicking, popping or discomfort in the jaw?..... YES___ NO ___
Do you clench or grind your teeth?.....YES ___ NO ___
Do you have sores or ulcers in your mouth?..... YES ___ NO ___
Do you wear partials or dentures?..... YES ___ NO ___
Have you ever had serious injury to your head or mouth?..... YES ___ NO ___
If YES, please explain and when _____
Have you ever had difficulties associated with any dental work?.....YES___ NO___
Have your tonsils or adenoids been removed?..... YES ___ NO ___
If YES, when? _____
Do you wear a CPAP?..... YES ___ NO ___
Have you been diagnosed with sleep apnea or do you snore? ..... YES___ NO ___
Do you have dental implants?..... YES ___ NO ___
If YES, how many? Locations? _____
Do you use tobacco? YES ___ NO ___ If yes, what type? _____
If so, are you interested in stopping? Very_____ Somewhat_____ Not Interested _____
Do you use controlled substances(drugs)?..... YES ___ NO ___

How do you feel about your smile?

_____

-Your Medical History-

Please circle your response if you have or have not had any of the following diseases or problems:

Abnormal Bleeding	YES	NO	Herpes / Fever Blisters	YES	NO
Alcohol / Drug Use	YES	NO	High Blood Pressure	YES	NO
Anemia	YES	NO	HIV/AIDS	YES	NO
Artificial Joints	YES	NO	Jaundice	YES	NO
Arthritis	YES	NO	Kidney Problems	YES	NO
Asthma	YES	NO	Liver Problems	YES	NO
Blood Disease	YES	NO	Low Blood Pressure	YES	NO
Cancer	YES	NO	Pacemaker	YES	NO
Diabetes	YES	NO	Mental/Nervous Disorder	YES	NO
Dizziness/Fainting Spells	YES	NO	Rheumatic Fever	YES	NO
Emphysema	YES	NO	Rheumatism	YES	NO
Epilepsy/Seizures	YES	NO	Sinus Problems/Hay Fever	YES	NO
Frequent Headaches	YES	NO	Stroke	YES	NO
Glaucoma	YES	NO	Stomach Problems	YES	NO
Heart Attack	YES	NO	Thyroid Problems	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Tumors	YES	NO
Heart Surgery	YES	NO	Ulcers	YES	NO
Hepatitis	YES	NO	Venereal Disease	YES	NO

If not listed above, please list _____

_____

-Your Medical History-

Do you consider yourself in good medical health? ..... YES___ NO ___
Has there been any change in your general health within the past year? YES __ NO ___
If YES, please list: _____
Are you under the care of a physician?..... YES ___ NO__
Current physician's name & phone number_____
Condition for which you are being treated _____
Date of last physical exam _____
Are you under the care of a specialist?..... YES ___ NO___
If YES, please list physician name & phone number _____
Are you taking any medication, vitamins or supplements?..... YES___ NO ___
If so, please list here or provide a printed list_____
_____
Are you allergic to any medications? ..... YES___ NO___
If so, please list here_____
Do you have any other allergies? _____
Recent Surgeries? Doctors & Dates _____

-Women-

Are you currently or possibly pregnant?.....YES___ NO___
If so, how many weeks? _____ Are you nursing? ..... YES___ NO___
Are you taking birth control ?.....YES___ NO___
Have you been diagnosed with Osteoporosis? .....YES___ NO___
Medication for Osteoporosis, past or present? _____

-Acknowledgement & Authorization for Treatment-

I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE_____DATE_____

-Dental Insurance Information-

Insured's Name _____Relationship to Patient_____

Insurance Company Name _____

Insured's Social Security # _____Birth Date _____

Group Number_____ Insurance Co. Phone_____

Our Policy
Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which may reduce your immediate out-of-pocket expense.

We will provide you with an estimate of what your insurance may pay. It is based on limited information provided to us by your insurance company. Your patient portion is only an estimate, because we can never know for sure what your insurance company will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

Dental insurance companies normally do not require a "predetermination" or "prior authorization". If the insurance company does, we will be happy to submit a treatment plan to them. In order for us to submit your form, we ask that you provide the following:

1. A copy of your insurance card.

2. Information on the subscriber, such as insured's birth date, social security number, group or ID number, and the name of employee, whichever is applicable.

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance.

Signature _____ Date _____

Payment Policy

Please read and initial the following statements regarding insurance and payment policies.

____ I understand that Dr. Buntyn files and receives payments from most insurance carriers allowing most patients the use of their primary carrier benefits.

____I understand that my dental insurance is a contract between myself and my insurance carrier and that I am responsible for all charges incurred during treatment.

___I understand that the payments made by my insurance company are based on the contract negotiated between my employer and the insurance company.

____I understand that my **estimated** portion of the fee for service is due on or before the day of my appointment depending on the type of treatment and length of appointment. When Dr. Buntyn has received payment from my insurance company, I will be billed for any remaining balance. That balance will be due within 14 days.

___ I understand that if I have secondary insurance, Dr. Buntyn will file the secondary insurance as a courtesy to me. If secondary insurance does not make a payment toward the filed claim within 60 days of initial treatment date, the remaining balance is due.

___ I understand that Dr. Buntyn will do everything possible to maximize my insurance benefits but that Dr. Buntyn will recommend treatment based on his professional training and what he feels is best for me.

___I understand that I may be requested to assist with getting claims processed by my insurance company in a timely manner.

___I understand that it is my responsibility to inform Dr. Buntyn of any changes in my insurance coverage, maximum benefits, insurance benefits used, etc.

___I understand that in addition to filing and accepting insurance payments,
Dr. Buntyn also offers financing options through Care Credit.

I have read and understand the above.

_____ _____

Patient's Signature Date

-Your Account Responsibility-

Who is responsible for this account? _____Self _____Other

If other party besides patient is responsible for account please fill out below:

Responsible Party's Full Name _____

Address _____City _____State _____ Zip_____

Birth Date _____ Age _____ Social Security # _____

-Your Financial Responsibility-

I understand that I am responsible for all charges incurred during treatment. Payment is due on or before the day of service depending on type of treatment and length of appointment. If any remaining balance after insurance has assisted has not been paid after 60 days, it will be sent to a collections agency for processing. Payment methods available include all major credit cards, cash or check. Financing options are also available through Care Credit.

INITIAL_____ DATE _____

-Your Cancelled or Missed Appointment Policy-

Please notify us of any appointment changes 48 hours or more before the scheduled appointment. If notification is not given in a timely manner, there will be a **$65 Cancellation Fee per hour** for the time that was reserved for you.

INITIAL_____ DATE _____

I have read and understand the above statements concerning: Account Responsibility, Financial Responsibility and Cancelled or Missed Appoinments.

SIGNATURE_____DATE_____