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 ___

Do you have dental implants?.....
YES ___ NO ___
If YES, how many? Locations?

_____
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? _____
Have you been diagnosed with sleep apnea or do you snore? ..... YES___ NO ___
Do you wear a CPAP?.....
YES ___ NO ___
Do you use tobacco or Vape? 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 ___

If you could change one thing about your smile, what would it be?

_____

-Your Medical History-

Please circle your response if you currently have, have history of 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	Low Blood Pressure	YES	NO
Artificial Joints	YES	NO	Stroke	YES	NO
Arthritis	YES	NO	Kidney Problems	YES	NO
Respiratory Disease	YES	NO	Liver Problems	YES	NO

Blood Disease	YES	NO	Autoimmune Disorder	YES	NO
Glaucoma	YES	NO	Dementia/ Alzheimer's	YES	NO
Cancer Type:	YES	NO	Mental/Nervous Disorder	YES	NO
Diabetes A1C:	YES	NO	Neurodevelopmental Disorder	YES	NO
Dizziness/ Fainting Spells	YES	NO	Rheumatism	YES	NO
Emphysema	YES	NO	Acid Reflux/GERD	YES	NO
Epilepsy/ Seizures	YES	NO	Stomach Problems	YES	NO
Frequent Headaches	YES	NO	Thyroid Problems	YES	NO
Sinus Problems	YES	NO	Tuberculosis	YES	NO
Heart Attack	YES	NO	Tumors	YES	NO
Heart Disease	YES	NO	Ulcers	YES	NO
Heart Murmur	YES	NO	HIV/AIDS	YES	NO
Heart Surgery	YES	NO	Venereal Disease	YES	NO
Pacemaker	YES	NO	Hepatitis	YES	NO

If you circled YES above, please explain_____

_____

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 or Hospitalizations? 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. I authorize my dental team to communicate my health information to my healthcare provider.

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 may 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.

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.

Please read and initial the following statements regarding 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. Dr. Buntyn is not a participating provider for any insurance company.

____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 policy 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 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.

-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.

-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, you will be responsible for the total appointment fee for the time that was reserved for you.

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

SIGNATURE_____DATE_____

Authorization for Use and Disclosure of Health Information for Educational Purposes

Committed to continuing education, Dr. Buntyn regularly takes and presents continuing education courses on Cosmetic Dentistry, Temporomandibular Joint (TMJ) rehabilitation, Endodontic Therapy, Conscious Sedation, Dental Implants and other dental topics.

I authorize the use and disclosure of my health information for educational and professional development purposes, including presentations, lectures, seminars, and training sessions.

The information that may be used or disclosed includes: Clinical records, Radiographs/imaging (e.g., X-rays, CBCT scans), Photographs (intraoral and/or extraoral), Videos

This information may be presented:

- In live lectures, conferences, or classroom settings
- In recorded presentations or educational materials
- To audiences that may include dental professionals, students, and trainees

I understand that once disclosed in these settings, the information may not be fully controllable or retractable.

My information will be **de-identified** to the extent possible.

I understand that despite efforts to remove identifying details, there is a possibility I could still be recognized, especially if images or unique clinical features are used.

I acknowledge that I have read and understand this authorization. I have had the opportunity to ask questions and receive answers.

SIGNATURE_____DATE_____

I understand the request to use and/or disclose my health information for educational and lecture purposes. I **do not authorize** the use or disclosure of my information for these purposes.

I understand that my decision to refuse will not affect my treatment, payment, or eligibility for benefits.

SIGNATURE_____DATE_____