Welcome to Broadway Family Dentistry

We understand that going to the dentist may not have been on top of your “to do” list. Whether it has been 6 months or 6 years since your last visit, we are glad to have you. Thank you for choosing our office for your dental care.

Please help us give you the best care possible by taking some time and filling out the forms that follow. Not only will that assist us in providing you with the highest quality of care, but it will also help us to save you time waiting in our office. We request that you fill everything out to the best of your knowledge, including any applicable insurance information.

If you think you have dental insurance benefits and do not have a card, please check with your employer/HR representative before your appointment so there are not any unnecessary surprises for you at your first visit.

X-RAYS: If you have seen a dentist within the last year had radiographs (x-rays) taken, please contact your prior office to see if they can be transferred. In the event that current X-rays are not available or are not received prior to your reserved appointment, it will be in your best interest to take new ones so that we can adequately examine your mouth.

Patient Information

First Name | Last Name | Middle Initial

Address

City | State | Zip

Home phone | Work phone | Cell phone

Email address

May we contact you by email?

Patient Social Security Number | Patient Date of Birth | Gender

Preferred Pharmacy

Responsible Party (if patient is under 18 or someone else has power of attorney of healthcare)

First Name | Middle Name | Last Name

Street

City | State | Zip

Home Phone | Work Phone | Cell Phone

Soc. Sec. No. | Date of Birth | Gender

How did you hear about our office? (Newspaper Radio TV Internet Referral Other?)

_____

Insurance Information

Do you have Dental Insurance? _____ Do you have Secondary Dental Insurance? _____
Please bring your insurance card to our office on your visit to make a copy for your chart

Primary Insurance

Subscriber Name

Subscriber SSN

Date of Birth

Relationship to Subscriber

Employer Name

Employer Phone

Insurance Company

Insurance Group #

Insurance Phone #

Secondary Insurance

Subscriber Name

Subscriber SSN

Date of Birth

Relationship to Subscriber

Employer Name

Employer Phone

Insurance Company

Insurance Group #

Insurance Phone #

Broadway Family Dentistry
Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily teat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

please select

Are you under a physician's care now? If yes

Have you ever been hospitalized or had a major operation? If yes

Have you ever had a serious head or neck injury? If yes

Are you taking any medicaitons, pills or drugs? If yes

Do you take, or have you taken Phen-Fen or Redux? If yes

Have you even taken Fosamax, Boniva, Actonel or any If yes

Are you on a special diet? If yes

Do you use tobacco? If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraception

Are you allegic to any of the following? (check all that apply)

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other allergies? Please describe

Do you use controlled substances? If yes

Do you have, or have you had, any of the following? (Choose Yes or No)			
AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growth
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Verereal Disease
			Yellow Jaundice

Have you ever had any serious illness not listed? If yes

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian Date

We screen for both TMJ/Facial pain problems as well as Sleep Disordered Breathing problems at our office because it can affect other aspects of your health. Please answer honestly.

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Please check any of the following symptoms you have experienced. If appropriate include how often they occur.			
Headaches		how often	
TMJ Pain		how often	
TMJ Noise		how often	
Limited Opening		how often	
Vertigo (Dizziness)		how often	
Tinnitus (Ringing in ears)		how often	
Dysphagia (difficulty swallowing)		how often	
Loose Teeth		how often	
Clenching/Bruxing		how often	
Facial Pain (Nonspecific)		how often	
Tender, Sensitive Teeth (Percussion)		how often	
Difficulty Chewing		how often	
Cervical/Neck Pain		how often	
Postural Problems		how often	
Paresthesia/Tingling of Fingertips		how often	
Thermal Sensitivity (Hot/Cold)		how often	
Trigeninal Neuralgia (Type of Facial Pain)		how often	
Bells Palsy (Drooping of Face)		how often	
Nervousness/Insomnia		how often	

Do you have morning headaches?	Please select	Do you wake up tired?	Please select
Do you gasp for breath at night?	Please select	How long do you sleep at night?	hours
Have you had a sleep study?	Please select	Are you currently wearing a C-PAP?	Please select

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?

Sitting and reading		Use the scale beside each situation and chose the most appropriate response. Add up all the scores. A score of 8 or more indicates the possibility of sleep disordered breathing.
Watching television		
Sitting inactive in a public place (i.e. theater)		
As a car passenger for an hour without a break		
Lying down to rest in the afternoon		
Sitting and talking to someone		
Sitting quietly at lunch without alcohol		
In a car, while stopping for a few minutes in traffic		

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her physically and emotionally.

My snoring affects my relationship with my partner		Use the scale beside each situation and chose the most appropriate number for each situation. Add up all the scores. A score of 5 or greater indicates your snoring may be significantly affecting your quality of life.
My snoring causes my partner to be irritable or tired		
My snoring requires us to sleep in separate rooms		
My snoring is loud		
My snoring affects people when I am sleeping away from home (hotel, camping, etc.		

CANCELLATION AND FINANCIAL POLICY

1. CANCELLATIONS: We reserve time with our doctors and their team for you in the schedule. To help us continue to provide top notch service, it is requested that you notify us at least 24 hours in advance if you need to change your reserved appointment. If you do not notify us at least 24 hours in advance, we reserve the right to collect a $75 cancellation fee. Thank you in advance for the courtesy.

2. PAYMENT POLICY: The following payment policies apply;
a. Payment in full of the Patient Financial Responsibility amount, as specified in the Treatment Financial Arrangement Form, is due no later than when services are rendered. Acceptable forms of payment include cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits and select financing programs.
b. For comprehensive treatment plans requiring multiple office visits or appointment times longer than 90 minutes, a minimum deposit of 50% of the patient financial responsibility amount is required.
c. You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans.

3. THIRD PARTY FINANCING DISCLOSURE
Broadway Family Dentistry accepts payment from non-affiliated, third party lenders (ie. CareCredit or Springstone). Broadway Family Dentistry pays these companies fees on a sliding scale for making loans available to patients like you and for the lender's cost of servicing these loans. The sliding scale used to calculate fees through these companies does not affect your treatment costs.

RECEIPT OF CANCELLATION AND FINANCIAL POLICIES AND PRIVACY PRACTICES

1. Cancellation and Financial Policy - By signing below, I acknowledge that I received the Cancellation and Financial Policies form and agree to abide by such policies.

Signature_____Date_____

2. Notice of Privacy Practices (must be signed by all new patients) - By signing below, I acknowledge that I have read Broadway Family Dentistry's Notice of Privacy Practices, as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____ Date_____

Click on this button to submit form as email

Broadway Family Dentistry

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 carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY
Broadway Family Dentistry ("we," "our," "us"), like all other medical and dental practices, is required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this notice about our 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 went into effect April 14, 2003 with the latest revision May 20, 2015 and will remain in effect until modified or replaced. 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 in 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 according to the means outlined in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician/dentist, dental auxiliaries, students and other healthcare providers 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 performances, 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 prescriptions, dental supplies, X-rays, or other similar forms of health information.
Marketing Health-Related Services: We may use Patient Information internally to offer goods and services we believe may be of interest.
We may utilize one or more third-party service providers to send email or other communications to you on our behalf, including Patient satisfaction surveys. These service providers are prohibited from using your email address or other contact information for any purpose other than to send communications on our behalf.
It is our intention to only send email communications that would be useful to you and that you want to receive. When you provide us with your email address as part of the registration or appointment setting process, we will place you on our list of patients to receive informational and promotional emails.
Each time you receive a promotional email, you will be provided the choice to "opt-out" of future emails by following the instructions provided in the email, or you can "opt-out" at any time by following the instructions provided.
Fundraising: We will not use your health information for fundraising activities without your written consent.
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 a correctional institution or law enforcement official having lawful custody of protected health information of an 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, email, texts, 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 per page and per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you.)
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 treatment, payment, healthcare operations and certain other activities for the last 5 years, but not before April 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). When you pay in full outside of your insurance plan for services you may request that we restrict this information and not disclose it to your healthcare plan or insurer.
Breach Notification: We will provide you with notification of a breach of unsecured PHI as required by law.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of 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. This 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 received this notice on our web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form at your request.

QUESTIONS AND CONCERNS
If you would like additional information about our privacy practices or have questions, Aspen Dental's HIPAA Compliance Officer may be reached at 800-996-6470, extension 1250.
If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or our handling of your 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 send your concerns to Broadway Family Dentistry; 1839 South Broadway; Minot, ND 58701.You also may submit written concerns to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.
We support your right to maintain 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 Services.
Contact Officer: Lynn Pedie, Office Manager at Broadway Family Dentistry 701-839-1299