

ACQUAINTANCE FORM

Welcome to Buehner Family Dental Care! *It is important that we get to know you, including your dental and medical history. Many things have a direct impact on our dental health. We will review this questionnaire and discuss it with you in detail during your exam. The information you give us is strictly confidential and will not be released to anyone without your permission. Please share how you found our office.*

(Please circle) Magazine Google Location Insurance Personal Referral: _____

PATIENT INFORMATION

Patient's Name: _____ Male ___ Female ___
Spouse's Name: _____ Marital Status: S ___ M ___ D ___
Address _____ Phone: Home _____
City, State Zip _____ Cell _____
Email _____
Social Security # _____ Date of Birth _____
Employer Name _____ Work Telephone _____

EMERGENCY INFORMATION

In Case of Emergency Contact: _____ Relationship: _____
Telephone _____

RESPONSIBLE PARTY INFORMATION

If self, check here: _____

Person Responsible for Payment _____ Relationship to patient: _____
Address: _____ Telephone: _____
Social Security # _____ Date of Birth _____ Are they a Patient here: Y / N

INSURANCE INFORMATION

Dental Insurance Company Name: _____ Employer: _____
Group#/Policy # _____ Subscriber Name: _____
if other than self: Social Security # _____ DOB: _____ Relationship: _____

IF DUAL COVERAGE--THE SECONDARY INSURANCE COMPANY:

Dental Insurance Company Name: _____ Employer: _____
Group#/Policy # _____ Subscriber Name: _____
if other than self: Social Security # _____ DOB: _____ Relationship: _____

If no insurance, are you interested in our Sweet Tooth Savings Program? _____

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION Initials: _____

By initialing this section, you will consent to our use and disclosure of your protected health information to the following individuals, to carry out treatment, payment activities, and healthcare operations. (Spouse/parents/children/care giver)

Name: _____, Relationship: _____
Name: _____, Relationship: _____
Name: _____, Relationship: _____
Name: _____, Relationship: _____

MEDICAL HISTORY

Please check ✓ any of the following which you have or have had and explain where necessary.

***In the lines provided, LIST ANY PRESCRIBED MEDICATIONS  you are taking now for this problem. ***

- 1. AIDs _____
- 2. Anemias or Blood Discrasias _____
- 3. Arthritis, Rheumatoid or Osteo _____
- 4. Asthma _____
- 5. Autoimmune Problems _____
- 6. Birth Control Pills, Hormone Replacement Therapy or Fertility Problems _____
- 7. Blood Clots or Stroke: Y/N Treatment: _____
- 8. Bone Problems, Osteoporosis
Treatment w/Bisphosphonates (Please circle or write): Fosamax Actonel Boniva Zometa oral or injection
Other: _____
- 9. Cancer or Tumors: Y/N Current Treatment: _____ Previous Treatment: _____
- 10. Depression or Nervous Disorders _____
- 11. Diabetes: Type I or Type II
A. Oral Medication _____ B. Insulin Injections _____
- 12. Digestion Problems, Acid Reflux, GERD _____
- 13. Epilepsy or Seizures: Y/N Last episode: _____
- 14. Hayfever or Allergies other than medications _____
- 15. Heart Problems _____
A. Cardiac Bypass Surgery _____ B. Cardiac Pacemaker _____
C. Congenital Heart Defect _____ D. Prosthetic Heart Valve _____
E. Heart Attack _____ F. Heart Murmur, Mitral Valve Prolapse _____
- 16. Hepatitis A, B, C or Liver Disease _____
- 17. High Blood Pressure _____ 18. Low Blood Pressure _____
- 19. Joint Replacement _____ Premedication: Y/N Antibiotic: _____
- 20. Kidney Problems _____
- 21. Lung Disease, COPD _____
- 22. Muscle diseases _____
- 23. Social Diseases _____
- 24. Thyroid Diseases _____
- 25. Tuberculosis or Symptoms of Tuberculosis _____
- 26. Other diseases not listed _____

Along with the medications listed above. Please list any additional medications, vitamins, supplements, or herbal/homeopathic remedies that you are currently taking: _____

Are you allergic to any of the following:

- Antibiotics 1. Penicillin 2. Erythromycin 3. Tetracycline 4. Sulfa 5. Keflex 6. Clindamycin
- 7. Other _____
- Local Anesthetics like Lidocaine or Septocaine or Carbocaine Epinephrine sensitivity _____
- Aspirin Codeine Ibuprofen, Motrin, Advil Aleve Narcotics _____
- Latex Metals of any kind _____
- Other allergies to materials or medications _____

Have you ever been advised to take medication (antibiotics or other medications) before a dental appointment? Y/N (circle) If so, please explain _____

Have you ever had a skin rash or a reaction to metal jewelry? Y/N (circle) To What? _____

Do you wear contact lens? Y/N (circle) Do you bleed excessively upon injury? Y/N (circle)

Do you drink alcohol? Y/N (circle) _____ daily _____ weekly _____ monthly _____ socially _____

Do you smoke now or **have you ever** smoked? Y/N (if yes number of years) cigarettes/day _____
cigars _____ pipes _____ chewing tobacco or snuff _____

Women: Is there a possibility that you may be pregnant or trying to get pregnant? Y/N (circle)

If yes, how many months pregnant? _____

Are you in a job that regularly exposes you to radiation or chemicals? Y/N (circle) _____

Have you ever had counseling for addictions to alcohol and/or prescription medications? Y/N (circle)

Do you have reason to believe you are at risk for contacting infectious or sexually transmitted diseases?

Y/N (circle) If yes, please explain _____

Have you been a patient in the hospital in the past two years Y/N (circle) If so, please explain _____

Date of last medical visit for a checkup or physical (month/year) _____

Physicians name, address and phone number: _____

Are you experiencing emotional or physical stress or pressure in your work or at home? Y/N (circle)

Please explain _____

Is there anything other in your medical history that we have missed? _____

DENTAL HISTORY

When was your most recent dental appointment? _____

Dentist/Office Name _____ Office City, State and Phone Number _____

What service was rendered? _____ Were x-rays taken? Y/N (circle) _____

When was the last time x-rays were taken of your teeth? _____

Did you have a: Panoramic x-ray (PAN) full series bite-wings CBCT(Cone Beam)

Have you had regular cleaning and exams? Y/N (circle)

Do you have a fear or phobia of the dentist that prevents you from visiting the dentist on a regular basis? Y/N (circle)

Would you be interested in help to deal with this fear, such as the use of Nitrous Oxide? Y/N (circle)

Have you lost teeth? Y/N (circle) Why? _____

Have you had complications with extractions? _____

Have you worn braces? _____ When? _____ How Long? _____ Do you still wear retainers? _____

Have you had treatment for periodontal disease (gum disease) or where you told you had periodontal disease? _____ Please explain and give dates _____

How often do you brush your teeth? _____ x/day AM _____ PM _____ How often do you floss? _____

Do you use other hygiene aids? _____

Do your gums bleed when you brush? _____ or floss? _____

Do you have an unpleasant taste in your mouth? _____

Are there any areas of your mouth where foods collect or wedges between your teeth? _____

Have you noticed a dry mouth? Y/N Excessive water drinking/sipping? Y/N Frequent Use of Lozenges? Y/N

Do you have clicking or popping sounds when you open or close your mouth? _____ Pain? _____

Do you clench or grind your teeth either during the day or at night? _____

Do you experience headaches? _____ Frequency? _____ When do they come? _____

Are any of your teeth sensitive? _____ Sweets? _____ Cold? _____ Hot? _____ Pressure? _____

Are you interested in mercury safe removal of amalgam (mercury) fillings? _____

Is there anything about the appearance of your smile that you would like to change? _____

Are you interested in or have questions about:

clear aligners (orthodontics) dental implants whitening biocompatibility testing

What is your primary concern today? _____

TREATMENT AUTHORIZATION

I consent to routine dental care recommended by my provider, including necessary diagnostic procedures and appropriate local anesthetics. I understand that I will be informed of any proposed treatment that goes beyond routine care.

I understand that payment for services is my responsibility, regardless of insurance coverage or any third-party involvement.

Signature of Patient or _____ Date _____

Signature of Guardian on behalf of minor _____ Date _____

Signature of Dentist _____ Date _____



BUEHNER FAMILY DENTAL CARE

Co-Insurance and Deductible Policy

Thank you for choosing us for your dental care. We are committed to providing high-quality treatment and a positive experience for every patient. As part of our participation agreements with insurance companies, **we are required to collect any applicable co-insurance, deductibles, and non-covered service fees at the time of service.**

If you have concerns about paying your portion on the day of your visit, please speak with our front desk team before treatment begins. We are happy to review your estimated benefits and discuss payment arrangements when needed. A portion of the co-insurance or deductible must be paid on the date of service for any arrangement to be made.

Insurance benefits, including allowed amounts and “usual and customary” rates, are determined by the plan selected by you or your employer. These amounts do not reflect our actual fees. Our fees are based on the time, materials, and expertise required to provide high-quality care. Treatment recommendations are always based on your clinical needs, not on insurance coverage.

Please note that your dental insurance contract is an agreement between you and your insurance company. While we will assist you in maximizing your benefits, any balance not covered by your plan is ultimately your responsibility.

I have read and understand this policy and agree to its terms. I understand that the office may update this policy as needed.

Signature of Patient or _____ Date _____

Signature of Guardian on behalf of minor _____ Date _____

Printed Name of Signor: _____

Relationship to Patient: _____

Thank you for choosing us for your dental care. We are committed to providing high-quality treatment and clear communication regarding financial responsibilities. Please review the following policies and sign below.

Payment for Services: **Payment is due at the time of service** unless other arrangements have been made in advance. We accept cash, check, Visa, MasterCard, Discover, American Express, and CareCredit.

Returned checks will incur a \$50 processing fee.

Insurance & Patient Responsibility: As a courtesy, we will submit dental insurance claims on your behalf. To do so, we require accurate and current insurance information prior to your appointment.

Please understand:

- Your dental insurance contract is an agreement between you and your insurance company.
- Any portion not covered by your plan, including deductibles, co-insurance, non-covered services, and amounts applied to your annual maximum, is your responsibility.
- We collect **estimated** patient portions at the time of service, based on the information available to us.
- If your insurance does not remit payment within 45 days, the remaining balance becomes your responsibility. Any remaining balance or overpayment will be reconciled after insurance responds.

Our treatment recommendations are based on clinical need and are not determined by insurance coverage.

Fees, Estimates & Billing: We will review recommended treatment and associated fees before care begins. Any remaining balance after insurance payment will be billed to you. Overpayments will be refunded promptly. Our fees reflect the time, materials, and expertise required to provide high-quality care and may not match your insurance company's "usual and customary" allowances.

Missed Appointments: Your appointment time is reserved exclusively for you. Missed appointments or changes with less than 48 business hours' notice may result in a \$50 per scheduled hour fee.

Past Due Balances & Collections: Balances not paid within 30 days will receive a monthly statement. Accounts that remain unpaid may be referred to a collection agency.

If your account is referred to collections, you may be responsible for:

- The collection agency's fee of **25%**, which reflects the actual cost charged to our office
- Any additional legal or court fees as permitted by Pennsylvania law

Good Faith Estimate (No Surprises Act): If you do not have insurance or are not using insurance, you have the right to receive a **Good Faith Estimate** explaining the expected cost of your care. You may request one at any time.

Acknowledgment: **I have read and understand the Financial Policy and agree to its terms. I understand that Buehner Family Dental Care may update this policy as needed.**

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____



**BUEHNER FAMILY
DENTAL CARE**

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 our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice takes effect 1/01/2023 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 the 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 listed at the end of 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 or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for the services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include but are not limited to 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 of disclosure permitted by your authorization while it was in effect. Unless you give us 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.

Person Involved in Care: We may use or disclose your health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to the use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstance, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in

your healthcare. We will 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 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 of 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients.

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. 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.

Restrictions: 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 a 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. **(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 website 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 contact 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 write to us using the contact information listed at the end of this notice. You also may 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 Services 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 Services.

Buehner Family Dental Care Office Manager: Meghann Skipper
Buehner Family Dental Care Owner: Dr. Ryan Buehner DMD
Address: 517 W. Sunbury St. Minersville, PA 17954
Office Phone Number: (570) 544-4446

*Please retain pages 1 & 2 of this notice for your records.



**BUEHNER FAMILY
DENTAL CARE**

Acknowledgment of Receipt of Notice of Privacy Practices

****You may Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practice.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ Communications Barriers prohibited obtaining the acknowledgment.

_____ An emergency prevented us from obtaining acknowledgement.

_____ Other (Please Specify) _____