Welcome to J. Brett Ryan DMD, the "North County Dentist". In order to facilitate your first appointment there are a number of documents in this packet that need to be reviewed and completed (see list below) as this will save time.

Owner's Welcome Letter
Patient Information Form
Medical & Dental History
Payment and Financing
Appointment Policy
Financial Agreement Understanding
Records Release Form
General Consent
Notice of Privacy Practices
Communication Authorization and Preferences

Please complete each form carefully and bring them to your first appointment. Be sure to arrive 15 minutes early. If possible, it would be even better if you could ***return them to the practice before your first appointment***. For your convenience you can scan and email them to frontdesk@northcountrydentist.com, mail them back, or stop by and drop them off. Our staff will review your information and enter it into our computer system to establish you as a patient in our practice.

For those patients who are transferring from another practice, it is very helpful for the clinical staff to have access to your previous records before your first appointment. Please complete and submit the included records release form to your previous dentist as soon as possible. We are happy to do it on your behalf, as well, if you return the release form to us.

Kind Regards,

J. Brett Ryan, DMD PC
93 Montcalm Street
Lake George, NY 12845
518-668-5457 *phone*
518-930-4650 *fax*
frontdesk@northcountrydentist.com

Greetings!

I am very excited that you have decided to join the practice, and look forward to meeting you.

Our **mission** at J. Brett Ryan DMD, PC is to produce unrivaled dental care with uncommon service.

To achieve this we have a **vision** of consistent quality of treatment that always exceeds your expectations. We will work to make our care affordable to any patient who is motivated to seek treatment. You will be attended to with particular individual care and attention through our work, personal interactions, and appearance. We seek to reflect the pride and majesty of the North Country, and strive to make you feel this particular pride through your experience with us.

Our staff is highly experienced, and perform their jobs with precision and alacrity. I am proud of the fact that the practice is able to offer expanded services beyond that of a traditional general dentist practice. This includes oral surgery, difficult root canals, implant restorations, and same-appointment crowns and bridges. Also, our hygiene staff is extremely efficient and comfortable treating patients with all stages of periodontal disease.

We encourage open and frank communication, so please feel free to contact us with any questions and I hope you find the following pages informative. I look forward to meeting you.

Sincerely,

J. Brett Ryan, DMD
Owner

Please Note: *All patient information is considered private and confidential, and therefore stored and maintained under secure conditions. We require this information in order to render treatment and service your account completely and accurately. Please refer to our Privacy Plan for specific details. Finally, unless you pay for treatment in-full at the time of service, or will not be allowing us to submit insurance claims (if applicable), items with an asterisk (*) are required.*

PATIENT INFORMATION FORM

*Last Name: ____

*First Name:______________________________ M.I.____

Preferred Name: _____________________________________

*Billing Address: ____

*City: _____________________________ *State ________ *Zip: ____________

*Home #: _____________________________ Work #: __________________________

Mobile #: ________________________________

Email: ____

~THIS IS OUR PREFERRED METHOD OF COMMUNICATION ~

*Gender: M / F *Birth Date: ____ /____ /_________ *SS#:_______________________________

How did you first hear about our office? *(circle one)*:

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_______________	

Whom may we thank for referring you to our practice?

____

*__**Head of Account**__ *(if different from above)*

Name of responsible party *(Last, First, M.I.)*:

____

Relationship to patient *(circle)*: Self Spouse Parent Other: _______________________________

*Billing Address *(if different from above)*: ____

*City: _____________________________ *State ________ *Zip: ____________

*Home #: _____________________________ Work #: __________________________

Mobile #: ________________________________

Email: ____

Birth Date: ____ /____ /________ SS#:____

Employment Information

Employer Name: ____

Emergency Contact Information

Name of Contact: ____

BEST Phone Number:____

PLEASE NOTE: *We will always consider the primary insured party to be the Head of Account. If you have a secondary insurance through a spouse or other relationship, please complete the "Secondary Insurance Information". The following sections regarding insurance information only need to be completed under the following conditions…*

1.) *If you have insurance, but your carrier does NOT provide you with a card*
2.) *If you would like us to submit claims and pre-estimates on your behalf to your insurance carrier*

Insurance Information (Primary)

Name of Insured *(Last, First, M.I.)*:

____

Relationship to patient *(circle)*: Self Spouse Parent Other: ________________________________

Insured Birth Date: ____ /____ /_______

Insurance Plan Name: _______________________________________

Insurance Co Phone #: _______________________________________

Claims Address: ____

City: ______________________________ State ________ Zip: ____________

Group #: ____

ID #: ____

Employer:____

Insurance Information (Secondary)

Name of Insured *(Last, First, M.I.)*:

____

Relationship to patient *(circle)*: Self Spouse Parent Other: ________________________________

Insured Birth Date: ____ /____ /_______

Insurance Plan Name: _______________________________________

Insurance Co Phone #: ______________________________________

Claims Address: ____

City: ______________________________ State ________ Zip: ____________

Group #: ____

ID #: ____

Employer:____

HEALTH HISTORY

Patient Name: ____

Date of Birth: __________________

1. Date of last physical exam: __________
2. Physician and Practice Name: ____
3. Physician's Phone#: ____________________
4. Have you ever been hospitalized for any *MAJOR* diseases or illness (if yes, explain below)? YES NO

____

____

5. Have you been under the care of a medical doctor during the past year (If yes, what for)? YES NO

____

____

6. Have you ever had any excessive bleeding requiring special treatment? YES NO

7. **Women Only:** Are you pregnant/trying to get pregnant/breast feeding? YES NO

8. Are you allergic to, or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic *Penicillin* *Codeine*

*Other Antibiotic:*______________ *Latex*

Acrylic *Metals:*______________ *Other:*____________________

*Describe your reaction :*____

9. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax *Actonel* *Boniva*

Aredia *Reclast* *Zometa*

*IF so, list duration:*____________________________________

10. Please list other medications you are taking:

____

____

____

____

11. Do you have, or have you EVER had any of the following conditions?

Condition			Condition		
Chest pain or Angina Pectoris	YES	NO	Fainting or Dizziness	YES	NO
Congestive Heart Failure	YES	NO	Ulcers	YES	NO
Heart Attack or MI	YES	NO	Ulcerative Colitis	YES	NO
Stroke or TIA	YES	NO	Other Gastrointestinal Problems: ___________________________	YES	NO
Other Cardiac Conditions: ___________________________	YES	NO	Sexually Transmitted Infection: ___________________________	YES	NO
High Blood Pressure	YES	NO	Recurring Cold Sores	YES	NO
Low Blood Pressure	YES	NO	Shingles	YES	NO
Artificial Heart Valve(s)	YES	NO	Epilepsy and/or Seizures	YES	NO
Mitrial Valve Prolapse	YES	NO	Diabetes Typer I or II (circle)	YES	NO
Other Heart Valve Conditions: __________________________	YES	NO	Any Kidney Disease ___________________________	YES	NO
Anemia	YES	NO	Any Thyroid Disorders ___________________________	YES	NO
Other Bleeding Disorder: __________________________	YES	NO	Frequent or Severe Headaches	YES	NO
Hepatitis A/B/C/D (circle)	YES	NO	Smoker - Current or Past (circle) How many packs/day: _______	YES	NO
Other Liver Disease: ___________________________	YES	NO	Consume alcohol Drinks/week:___________	YES	NO
Emphysema	YES	NO	Eating Disorder(s): ___________________________	YES	NO
Asthma	YES	NO	Cancer(s): ___________________________	YES	NO
Seasonal Allergies	YES	NO	Radiation Therapy (specify): ___________________________	YES	NO
Chronic Sinus Problems	YES	NO	Chemotherapy (specify): ___________________________	YES	NO
Tuberculosis	YES	NO	Joint Replacement (specify): ___________________________	YES	NO
General Shortness of Breath	YES	NO	Organ Transplant (specify): ___________________________	YES	NO

Dental History

Date of last dental exam:____________________

Date of last dental x-rays: ____

Are you having tooth or gum pain at this time?	YES	NO
Do you feel nervous about having dental treatment?	YES	NO
Have you ever had a bad experience in a dental office?	YES	NO
Do your gums bleed when brushing / flossing?	YES	NO
Have you ever had a "deep cleaning" (Scaling and Root Planing)?	YES	NO
Is there anything you would like to speak with the Doctor about in private?	YES	NO

Do you have any of the following dental concerns or problems:

Clicking in jaw joint	YES	NO	Sensitivity to:	HOT	COLD	SWEETS
Pain in or around your ears	YES	NO	Swelling	YES	NO	
Bleeding Gums	YES	NO	Bad Breath	YES	NO	
Difficulty opening or closing	YES	NO	Bad Tastes	YES	NO	
Difficulty chewing	YES	NO	Food Catching	YES	NO	
Tooth Pain	YES	NO	Grinding	YES	NO	
History of trauma to jaw or face	YES	NO	Clenching	YES	NO	
Diagnosis of TMJ/TMD	YES	NO				

Other problems: ____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Patient Signature: ____

Date______________

Clinician's Signature____

Payment Forms and Financing

Part of the practice vision is that we want to make treatment affordable to anyone who is motivated to seek it and have a plethora of payment methods available to patients.

Payment Methods

Beyond cash and check, we accept ALL major credit cards for payment.

Dental Insurance

We are participating providers with the following insurance carriers

Delta Dental
MetLife
Empire BlueCross/Blue Shield
Aetna
GHI/Emblem
CSEA

If we are not a participating provider for you **WE ACCEPT ALMOST ALL MAJOR INSURANCE CARRIERS.** This means your benefits are effective with us and we will submit all claims on your behalf.

We DO NOT participate with Medicare or Medicaid

Financing/Payment Plans

For patients wanting a payment plan to finance treatment, we offer CareCredit. CareCredit allows you to break up the cost of treatment, with the interest being paid by the practice for the first six (6) month.

Discount Plan for Non-Insured Patients

For patients ***WITHOUT ANY DENTAL INSURANCE COVERAGE*** we are proud to offer two in-house discount plans to help with treatment costs. If requested, they have been attached for you to look over.

Appointment Policy

Well-planned appointments usually mean fewer trips to the dentist, resulting in less time away from work or school. ***We reserve your appointment time especially for you***, and ask that you respect the time of practice by keeping your appointment and being punctual. We understand that at times you may not be able to make your scheduled appointment. We will work to accommodate you as best we can, however *it is the policy of this practice that we require at least 24 business-hours notification for appointment cancellations, and 48 business-hours notification for appointments two (2) hours or more*. Patients who cancel with less notification, who are more than 10 minutes late for an appointment, or who do not show, will have caused a **broken appointment** and be liable for the following…

1st Broken Appointment: Notification to re-schedule
2nd Broken Appointment: A procedure-specific fee (see below) will be charged to you, not to your insurance company (if applicable)
3rd Broken Appointment: A second charge to you

BROKEN APPOINTMENT FEES:

CLEANINGS - $75 CROWN/BRIDGE - $200(per unit)
FILLINGS - $100(per unit) OTHER/MISC - $75
NEW PATIENT APPOINTMENT - $75

After the second broken appointment, you will not be allowed to re-schedule until the fee is paid. After the third broken appointment, you will be required to place a 50% down payment on treatment at the time of scheduling.

The practice also maintains a policy on ***persistent re-scheduling***. Patients who re-schedule, with adequate notice, the same treatment appointment more than three (3) times within six (6) weeks will be required to place a 50% non-refundable down-payment on their treatment in order to re-schedule.

We appreciate your understanding and adherence to these policies as it allows us to delivery the best care we can. The head of the account needs to acknowledge below

Name:____

Signature:____

Date:__________________

<u>Financial Understanding Agreement</u>

We understand that dental treatment can quickly become expensive because of the complex nature and resources required. It is therefore extremely important to establish a clear understanding of the responsibilities of the patient and the practice with regards to payment for services. We **highly encourage** patients with any issues, **whether current or anticipated**, with their account to communicate with us because that is the easiest way to resolve any problems. **<u>If you are willing to work with us, we are willing to work with you.</u>** Please read each statement below, and the head of the account needs to initial after each statement:

_____ Upon request, I will be provided with a estimate for any treatment to be given at this practice, and I will acknowledge this through a signed copy.

_____ If the estimate for my portion of any planned treatment exceeds $400 I will be required to acknowledge this by signing a copy of the treatment estimate.

_____ Payment is due when services are rendered, unless other arrangements have been made. This includes any applicable insurance co-payments.

_____ There will be a $35 fee for any payment that is returned for lack of funds

_____ I understand that a treatment estimate is not exact, and therefore final cost could vary due to any number of mitigating circumstances.

_____ My treatment date(s) will not be backdated. All services are billed on the appointment date and submitted to insurance carriers (if applicable).

_____ I understand that I will not be allowed to continue routine treatment at the practice if my balance exceeds $400 at any given time.

_____ Failure to pay my balance within 60 days will result in a finance charge of 2.0% to my outstanding balance, and I will receive a “Final Collections Notice” at that time.

_____ If my account has a balance over 90 days it will be considered delinquent and immediately sent to collections.

_____ (Insured Only) Dental insurance is a contract between myself and my insurance company, and that the practice is a third party to this. I understand that I am ultimately responsible for understanding the exact benefits of my plan and **<u>knowledge of benefits and eligibility is my responsibility</u>**.

continued on the next page…

_____ (Insured Only) I understand that all insurance plans are unique and that staff may not have the information specific of my plan available to them before my visit and I may be responsible for the full cost of the treatment visit.

_____ (Insured Only) I acknowledge that the practice staff submit claims and pre-estimates for treatment as an *addition and complimentary service to me,* but ***work diligently to get me the maximum benefit for my coverage***. I am responsible for payment regardless of the insurance company's arbitrary determination of fees, benefits and coverage.

_____ (Insured Only) If the practice staff cannot verify my insurance coverage by my appointment, I will be responsible for the entire amount for the visit

_____ (Insured Only) After 60 days, if for any reason your insurance carrier does not pay for treatment completed, the balance will become my responsibility to pay.

_____ (Insured Only) If available, I am required to keep a copy of my dental insurance card on file to aid the staff in submitting claims on my behalf.

RECORDS RELEASE REQUEST

Date of Request:__________

To: ____

(previous dentist)

Street Address: ____

City: ________________________________

State:__________ Zip Code:__________

I hereby authorized the release of all my records relevant to dental treatment. This is to include copies of radiographs, treatment notes, findings and pending/diagnosed treatment. Please release them to:

J. Brett Ryan DMD, PC
93 Montcalm Street
Lake George, NY 12845
518-668-5457 (phone)
518-930-4650 (fax)
frontdesk@northcountrydentist.com

If possible, electronic copies via email are preferred

Patient's Name (printed)_____________________________________

Date of Birth:__________________

Patient/Guardian Signature:___________________________________

GENERAL CONSENT FOR TREATMENT

I understand that the information I have given today is correct and to the best of my knowledge accurate, and furthermore understand that it is my responsibility to inform this office of any changes in my medical or dental status and history. If I fail to inform the dentist and staff of any changes to my medical or dental history, I understand that all treatment is rendered by the staff and dentist in good faith and I may jeopardize myself and the anticipated outcome of treatment(s) by not informing them of any changes.

I authorize the treating dentist and staff to perform any dental treatment and/or services that are deemed necessary and appropriate, along with any and all diagnostic means to form a coherent and comprehensive diagnosis. Before any treatment is rendered I will be informed of the procedure(s) to be performed, my diagnosis, the risks and benefits associated with the aforementioned procedure(s), and if requested the estimated cost of treatment before it is rendered. I acknowledge that with any dental procedure there are both implicit and explicit risks associated with any treatment. The general risks associated with dental care include, but are not limited to the following…pain, bleeding, damage to adjacent hard or soft tissue, temporary or permanent paresthesia/nerve damage/soft tissue damage due to local anesthetic injection, iatrogenic infection, irreversible pulpitis, tempromandibular disorder (temporary or permanent), and loss of existing tooth structure. I understand that I retain the ultimate decision associated with any treatment and that electing to have no treatment is an option, though strongly recommended against. I recognize that once I have verbally agreed to treatment that I have given my explicit consent for treatment and accept any and all risks associated with it.

I acknowledge that I am responsible for payment of any services that are rendered to me. It is the policy of this office that payment will be due at the time of service upon check-in at the front desk, and this applies to patients with and without dental insurance coverage.

Patient Name:____

Guardian (if needed):____

Patient/Guardian Signature:_____________________________________

Date:________________

This form was updated on 1 MAY 2017, all previous editions are obsolete

NOTICE OF PRIVACY PRACTICES (HIPPA)

Federal law require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with a **Notice of Privacy Practices**. A hard copy of our Notice is available at in the patient waiting area and online. If you prefer a paper copy, please ask a staff member for a copy of our Notice.

I acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient Name:____

Guardian (if needed):____

Patient/Guardian Signature:____________________________________

Date:________________

OFFICE USE ONLY

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

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify):

AUTHORIZATION FOR INFORMATION RELEASE AND COMMUNICATION

Without explicit consent, in accordance with federal law, **it is the policy of this practice to not discuss any PHI (protected health information) with anyone but the patient or legal guardian/proxy** (if applicable and allowed by law). If you would like us to be able to communicate with someone other than yourself, please indicate that preference by initialing next to each item below.

You may discuss my dental treatment with:

____ Patient Initials: ________

You may discuss my finances with:

____ Patient Initials: ________

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification

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COMMUNICATION PREFERECES

For speedier communication, we would like to know how you prefer to be contacted for appointment reminders. We prefer electronic means, either texting or e-mailing, because of their ease of use but do understand that some patients prefer traditional methods. Furthermore, in general, we encourage the use of e-mail to contact us with any questions.

PLEASE INDICATE BELOW YOUR COMMUNICATION PREFERENCE

We will use the information provided on your patient registration sheet

MOST PREFERRED CONTACT:

HOME PHONE / WORK PHONE / CELL PHONE - CALL / CELL PHONE - TEXT / EMAIL

NEXT PREFERRED CONTACT:

HOME PHONE / WORK PHONE / CELL PHONE - CALL / CELL PHONE - TEXT / EMAIL

If we have a specific, **ACCOUNT-RELATED** item, may we contact you via e-mail?

YES NO