The Bonner Dental Network, PC
Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell) _____

EMAIL Address_____ Emergency Contact _____ PH# _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please circle yes or no:

AIDS/HIV Y/N
Drug Allergies:
_____
_____
Anemia Y/N
Arthritis Y/N
Artificial Joints Y/N
Asthma Y/N
Blood Disease/Hemophilia Y/N
Cancer Y/N
Diabetes Y/N
Dizziness Y/N
Epilepsy Y/N

Excessive Bleeding Y/N
Fainting Y/N
Glaucoma Y/N
Growths Y/N
Hay Fever Y/N
Head Injuries Y/N
Heart Disease Y/N
Heart Murmur Y/N
Hepatitis Y/N
High Blood Pressure Y/N
Jaundice Y/N
Kidney Disease Y/N
Latex Allergy Y/N
Liver Disease Y/N

Mental Disorders Y/N
Mitral Valve Prolapse Y/N
Nervous Disorders Y/N
Pacemaker Y/N
Pregnant Y/N
Due date:_____
Radiation Treatment Y/N
Respiratory Problems Y/N
Rheumatic Fever Y/N
Rheumatism Y/N
Sinus Problems Y/N
Stomach Problems Y/N
Stroke Y/N

Tuberculosis Y/N
Tumors Y/N
Ulcers Y/N
Venereal Disease Y/N
OTHER:
☐ List Prescribed medications taken_____
_____
_____

☐
BP_____/_____

PULSE_____

RESP._____

Dental History

1. Do your gums bleed while brushing or flossing? __yes __no
2. Are your teeth sensitive to hot or cold liquids/foods? __yes __no
3. Are your teeth sensitive to sweet or sour liquids/foods? __yes __no
4. Do you feel pain to any of your teeth? __yes __no
5. Do you have any sores or lumps in or near your mouth? __yes __no
6. Have you had any head, neck or jaw injuries? __yes __no
   Clicking? __yes __no
   Difficulty in opening or closing? __yes __no
7. Do you clench or grind your teeth? __yes __no
8. Have you ever had prolonged bleeding following extractions? __yes __no
9. Do you bite your lips or cheeks frequently? __yes __no

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Please provide following information for emergency purposes only
- Physician or Medical facility: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____ Reviewed by: _____ Date: _____

General Consent For Treatment

I hereby consent to the performance of dental treatment upon _____ by The Bonner Dental Network, PC.
Patient Name

Such treatment will be explained to me and will not proceed without my acceptance. I reserve the right to ask specific questions before recommended treatment commences. The nature and purpose of the treatment rendered, possible hazards, and alternative methods of treatment will be fully explained to me. I understand the risks involved with proceeding with treatment. No guarantee, warranty, or assurance has been given to me that the treatment will be successful or to my complete satisfaction. This consent pertains to treatment rendered upon said patient while in the physical office of The Bonner Dental Network, PC. I understand that there is a 25% down payment for all scheduled treatment other than preventive care which is collected either in person or over the telephone.

_____ Date_____
Signature of Patient or Legal Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

The Bonner Dental Network, PC
Spouse or Responsible Party Information

The following is for: Individual responsible for non reimbursed insurance cost.

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

_____

Financial Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance, to expedite processing time, we will work with your insurance company to ensure that our services are billed properly, and that all necessary information is submitted with claims. Most insurance carriers are required to pay physicians within 30 days: however, the ultimate responsibility for timely payment of services lies with the patient. After 30 days, any outstanding account balance due to unpaid insurance claims will become your responsibility, and payment will be expected upon receipt of a statement.
Patients with secondary insurance, we will assist in collecting reimbursement for said services for an additional 30 days.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.
I also understand that Insurance estimates and Please Pay amounts are based on said insurer and are provided as a courtesy. In the event that your insurance carrier pays less than the estimated amounts, you are responsible for the unpaid balance. Contact your Human Resources Department and / or Insurance Carrier to get more details about your specific plans so you can understand your financial responsibility.

Please contact our Financial Manager to discuss your treatment plan and the payment options available to make it easy and convenient for you.

THERE IS BROKEN APPOINTMENT FEE FOR ALL APPOINTMENTS CANCELLED WITHIN 48 BUSINESS HOURS AS WELL AS NO SHOWS.

_____ Date: _____
Signature of patient, parent or guardian

HIPAA PRIVACY FORM

Consent for Use and Disclosure of Health Information

Info is for interacting with your insurance carrier as well as referrals to specialists only

Purpose: In cases where **Dr. Leslie Bonner** has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

The Bonner Dental Network

1700 17th Street NW SUITE 302

Washington, DC 20009

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____ Birth date _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Bonner
Office Phone: 202.249.9131 Fax: 202.249.2851
E-mail: **drbonner@thebonnerdentalnetwork.com**
Address: 1700 17th Street, NW SUITE 302
Washington, DC 20009

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.