O'BRIEN DENTAL

JOSEPH KYLE DONAGHEY, D.M.D.
MICHAEL O'BRIEN, D.M.D.

APPOINTMENT/COMMUNICATION SYSTEM INFORMATION

We have a communication and appointment system that utilizes e-mail and cell phones in addition to traditional mail and home telephone numbers. We do not give out this information or use it for any other purpose other than office communication. Better communication allows us to serve you more efficiently. The communication options are certainly the patient's choice but rest assured all information is kept in the strictest confidence and used only for communications from O'Brien Dental.

We provide our patients the option to participate in our online patient communication system. Some features include the ability to:

- Request/Confirm Appointments Online
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with 'STOP.' Standard Text Messaging rates apply

PLEASE VERIFY YOUR CONTACT INFORMATION

Name: ____

Cell Phone:______________________________ ___Check here to Opt Out of Text Messages

Email: ______________________________ ___Check here to Opt Out of Email

Best Contact Number (if different from above): ______________________________

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for O'Brien Dental in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for O'Brien Dental in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

______________________________ ______________________________

Signature Date

O'BRIEN DENTAL

MICHAEL O'BRIEN, D.M.D.
JOSEPH KYLE DONAGHEY, D.M.D.

THE BENEFITS OF A HAPPY, HEALTHY SMILE ARE IMMEASURABLE! OUR GOAL IS TO HELP YOU REACH AND MAINTAIN MAXIMUM ORAL HEALTH. PLEASE COMPLETE THE ENTIRE FORM BELOW. THE BETTER WE COMMUNICATE, THE BETTER WE CAN CARE FOR YOU.

ABOUT YOU

Today's Date:______________________________

Name: ______________________________
Last First MI Mr. Mrs. Ms. Dr.

prefer to be called: ______________________________

Best Contact Number:______________________________

Secondary or Work Number:______________________________

Birth date: __--------/______/______ SS#:______________________________

Local Address:______________________________
Apt/ Condo #

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email: ______________________________

Employer.______________________________

How long there?______________ Occupation:______________

Where & when are the best times to reach you?______________

Whom may we thank for referring you? ______________

Other family members seen by us:______________

Previous/Present Dentist:______________
(Please Circle)

Estimated time since last Dental Visit: ______________

SPOUSE

Their Name:______________________________

Employer:______________________________

Best Contact Number:______________________________

Birth date:______________________________

DENTAL INSURANCE

Insurance Co. Name______________________________

Insurance Co. Address: ______________________________

____

Insurance Co. Phone: ______________________________

Group # (Plan, Local or Policy #)______________________________

Insured's Name: ______________Relation:______________

Insured's Birthday:__/__/__ Insured's SS#: ______________

Insured's Employer: ______________________________

SECONDARY DENTAL INSURANCE

Insurance Co. Name______________________________

Insurance Co. Address:______________________________

____

Insurance Co. Phone: ______________________________

Group # (Plan, Local or Policy #):______________________________

Insured's Name: ______________Relation:______________

Insureds Birthday: __/__/__ Insured's SS#:______________

Insured's Employer: ______________________________

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name:______________Relation:______________

Work #______________Ext:________Home #:______________

UNIVERSITY STUDENTS

Driver's License #:______________________ State:______

Parent's Name:______________________________

Parent's Address:______________________________
Street City State Zip

Parent's Best contact number:______________________________

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack	Y N Psychiatric Problems
Y N Stroke	Y N Epilepsy/Seizures/Fainting
Y N Cancer/Chemotherapy	Y N Diabetes
Y N Heart Murmur	Y N Tuberculosis
Y N Rheumatic Fever	Y N Drug/Alcohol Abuse
Y N HIV+AIDS	Y N Venereal Disease
Y N Heart Surgery	Y N Hemophilia/Abnormal Bleeding
Y N Pacemaker	Y N Ulcers/Colitis/GERD
Y N Shingles	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Anemia
Y N Kidney Problems	Y N Radiation Treatment
Y N Artificial Bones/Joints	Y N Asthma
Y N Artificial Heart Valves	Y N Arthritis
Y N Sinus Problems	Y N Difficulty Breathing
Y N High Blood Pressure	Y N Hospitalized for Any Reason
Y N Low Blood Pressure	Y N Hepatitis
Y N Fever Blisters	Y N Blood Transfusion
Y N Severe/Frequent Headaches	Y N Emphysema
Y N Sleep Apnea	Y N Glaucoma

Please list any serious medical condition(s) that you have or had: ____
____
____
____
____
____
____
____

Are you allergic to any of the following?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	

Please list any other allergies:____-
____
____
____
____

For Women Are you taking birth control pills? No___ Yes ___

Are you pregnant? ___No ___Yes___ Week #:___________

Are you nursing? No Yes

MEDICAL HISTORY

Do you have a personal physician? ___ Yes ___ No

Physician's Name____________________________________

Phone # :____________________Date of last Visit::__________

Are you taking any prescription/over-the-counter drugs? ___ No __ Yes

Please list each one, use the back of this form if necessary:____________
____
____
____
____
____
____

Why have you come to the dentist today?

____
____

Are you currently in pain? No ___ Yes ___

Have you ever had a serious /difficult problem associated with any previous dental work? No___ Yes ________________

If yes, please explain: ____________________________________
____

Do you now or have you ever experienced pain / discomfort in your TMjoint (TMJ / TMD)? No ___ Yes ___

Your current dental health is: Good ___ Fair ___ Poor ___

Do you like your smile? No ___Yes ___

Do your gums ever bleed? No ___ Yes ___

____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

.____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I have read, understand, and agree to the office payment policy.

____

Signature **Date**

O'BRIEN DENTAL

Joseph Kyle Donaghey, D.M.D.
Michael O'Brien, D.M.D.

INSURANCE AND PAYMENT POLICY

If you have dental insurance, please provide us with all the information you have before your appointment so we can help you maximize your insurance benefits (Insurance card, contract number, group number, name of insured if other than patient, insured social security number, date of birth, and employer or policy holder). While we never base treatment needs or options on dental insurance, we do want to help you receive the appropriate coverage and benefits available in your plan. Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the numerous varieties of insurance contracts. In addition, many insurance companies will change their coverage or policies without notifying the providers. Dental insurance, unlike medical insurance, does not pay 100% of your treatment needs; dental insurance plans pay percentages of certain procedures. There is usually a patient portion for every procedure, and as a courtesy to you our office will provide you with an estimate of what your portion of the treatment will cost. This estimated amount is due at the time of service. As a service to our patients, our staff will file your insurance claim for you at no additional charge. If you have more than one insurance, we will file all additional insurances but our collections will be based on the primary insurance only. If your insurance pays more than we expect, any overpayment will be credited to your account or issued as a refund upon request. If the payment was made by credit card or care credit, the refund will be reduced by the amount charged by the credit company. If you have any questions or concerns about your coverage, please ask; we want to help and avoid any misunderstanding! **Initial here___**

QUOTATION OF DENTAL FEES

Dental fees quoted by this office are valid for 3 months from the date issued and are subject to change after this period.

PATIENTS WITHOUT DENTAL INSURANCE

Patients without dental insurance or patients with insurance policies that will not assign payments to us will be expected to pay at the time of treatment.

PAYMENT METHOD OPTIONS

Our payment options include cash, check (with proper credentials),VISA, MASTERCARD, AMEX and DISCOVER, credit cards as well as debit cards.

FINANCING OPTIONS

For patients who would like to make monthly payments for their treatment, our office offers an interest free way to finance the cost of treatment through a third party company called Care Credit. For qualified applicants, most treatment can be paid for interest free for the first 12 months.

I have read, understand and agree to the payment policy. I understand I am responsible for any and all fees, including any fees not paid by insurance for any reason, and any and all collections costs.

Responsible Party Signature:_________________________________Date:____________________

O'BRIEN DENTAL

Joseph Kyle Donaghey, D.M.D.
Michael O'Brien, D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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, healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice can be requested at the front desk of our office or by contacting our office at 334.821.8800 or ofßcemanager@obriendental.com

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation; and that we may decline to treat you or to continue treating you if you revoke this Consent. We do not subscribe to any encryption services, therefore all text and e-mail messages you receive from O 'Brien Dental will be in standard format.

Responsible Party:______________________________________ Date:____________________

COLLECTIONS AGREEMENT:

You will be given two phone calls and up to one paper statement until your account is 90 days overdue. O'Brien Dental reserves the right to turn your contact information over to a collection agency after this time period. The following must be signed to have treatment in our office.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

Responsible Party Signature:______________________________________Date:________________

I agree, in order for us to service my account or to collect monies I may owe, O'Brien Dental and/or our agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. O'Brien Dental may also contact me by sending text messages or emails or using any email addresses I provide. Methods of contacting me include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.
I/We have read this disclosure and agree that O Brien Dental, its employees, and/or agents may contact me/us as described above.

Responsible Party Signature:______________________________________Date:________________

O'BRIEN DENTAL

Joseph Kyle Donaghey, D.M.D.
Michael O'Brien, D.M.D.

ATTENTION PATIENTS – IN AN EFFORT TO STAY ON TIME AND REDUCE WAIT TIMES, PLEASE BE AWARE OF THE FOLLOWING:

- Short notice cancellations and broken appointments are the largest cause for fee increases. Cancellations without minimum notice may be subject to a fee. Patients will not be charged if a reasonable and unexpected emergency arises. The office reserves the right to make the final decision on all broken appointment fee charges.

- Generally, patients are seated in order of their appointments, not necessarily in order of arrival. Arriving early is acceptable, however, we may not be able to see you earlier than your appointed time.

- If you are late for your appointment, you may be asked to wait or to reschedule. If you are running late, please call ahead and allow us to try to keep your appointment time available.

- Multiple late or broken appointments may result in the end of the doctor/patient relationship. While we strive to accommodate all patients, the office reserves the right to refuse service to any patient who cannot keep their appointments.

- Patients who break a treatment appointment may be asked to place a $50.00 deposit to reschedule. The deposit will go towards the treatment appointment and will only be treated as a charge if the following appointment is broken.

- **INITIAL HERE**:______________________________

THANK YOU FOR YOUR COOPERATION IN HELPING US PROVIDE THE BEST DENTAL EXPERIENCE POSSIBLE!!