Address:
6940 Fair Oaks Blvd #D
Carmichael, CA 95608

BACKHUS
FAMILY DENTISTRY

Phone:
(916) 483-3417
Email:
drbackhus@gmail.com

PATIENT INFORMATION

Name_____Soc. Sec.#_____
Last Name First Name Middle
Name you go by_____ Spouses name/(Child: Parent's name)_____
Address_____
City_____State_____Zip code_____
Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced
Patient/Guardian employed by_____Occupation_____
Home phone_____ Cell phone_____ Business phone_____
Email address_____
Business address_____
Present position_____ How long?_____
Whom may we thank for referring you to our office?_____
In case of emergency, who should we notify?_____ Phone_____

INSURANCE

Person responsible for account_____
Last Name First Name Middle
Relationship to patient_____ Birth date_____Soc. Sec.#_____
Address (if different from patient's)_____Phone_____
City_____State_____ Zip code_____
Person responsible employed by_____ Occupation_____
Business address_____Business phone_____
Insurance company_____
Contract#_____Group#_____Subscriber#_____
Names of other dependents under this plan_____
Is patient covered by additional insurance? Yes___ No____
Subscriber name_____ Relationship to patient_____ Birth date_____
Insurance company_____Soc. Sec.#_____
Group#_____Subscriber#_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance with _____
Name of insurance company
and assign directly to Mark E. Backhus, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

HEALTH HISTORY

DENTAL HISTORY

Reason for today's visit_____

Previous dentist_____Address_____

Date of last dental care_____ Date of last dental x-rays_____

Do you have problems with any of the following?

Y	N	Bad breath	Y	N	Clenching teeth	Y	N	Sensitivity to hot
Y	N	Bleeding gums	Y	N	Loose fillings	Y	N	Sensitivity to sweets
Y	N	Clicking or popping jaw	Y	N	Broken fillings	Y	N	Discomfort when biting
Y	N	Food collection between teeth	Y	N	Recent dental pain	Y	N	Sores or growths in your mouth
Y	N	Grinding teeth	Y	N	Sensitivity to cold			

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's name_____ Physician's phone_____ Date of last visit_____

I. **CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question):**

Y N Is your general health good?
Y N Has there been a change in your health within the last year?
Y N Have you ever been hospitalized or had a serious illness?
If yes, describe._____

Y N Are you being treated by a physician now? For what? _____

Women:
Y N Are you pregnant? Y N Are you nursing? Y N Are you taking birth control pills?

II. **DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

Y	N	Abnormal bleeding	Y	N	Epilepsy	Y	N	Respiratory disease
Y	N	AIDS	Y	N	Fainting	Y	N	Rheumatic fever
Y	N	Anemia	Y	N	Glaucoma	Y	N	Scarlet fever
Y	N	Arthritis, Rheumatism	Y	N	Headaches	Y	N	Shortness of breath
Y	N	Artificial heart valves	Y	N	Heart murmur	Y	N	Sinus trouble
Y	N	Artificial joint	Y	N	Heart problems	Y	N	Skin rash
Y	N	Asthma	Y	N	Hepatitis (Type___)	Y	N	Stroke
Y	N	Back problems	Y	N	Herpes	Y	N	Swelling of feet or ankles
Y	N	Blood disease	Y	N	High blood pressure	Y	N	Swollen neck glands
Y	N	Cancer	Y	N	HIV positive	Y	N	Thyroid problems
Y	N	Chemical dependency	Y	N	Jaundice	Y	N	Tuberculosis
Y	N	Chemotherapy	Y	N	Jaw pain	Y	N	Tumor or growth on head or neck
Y	N	Circulatory problems	Y	N	Kidney disease			
Y	N	Congenital heart defects	Y	N	Liver disease	Y	N	Use of bisphosphonates
Y	N	Contact lenses	Y	N	Mitral valve prolapse	Y	N	Ulcer
Y	N	Cortisone treatments	Y	N	Nervous problems	Y	N	Venereal disease
Y	N	Cough, persistent	Y	N	Pacemaker	Y	N	Weight loss (unexplained)
Y	N	Diabetes	Y	N	Psychiatric care			
Y	N	Emphysema	Y	N	Radiation treatment			

III. **HAVE YOU EVER USED?** Y N Tobacco in any form Y N Alcohol Y N Recreational drugs

IV. Do you or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain:_____

MEDICATIONS	ALLERGIES
List all medications you are currently taking _____ _____ _____	Yes No Aspirin Yes No Penicillin Yes No Codeine Yes No Sulfa Yes No Local Anesthetics Yes No Latex Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Print Patient Name:_____

Patient/Guardian Signature_____ Dentist Initials_____ Date_____

BACKHUS
FAMILY DENTISTRY

Office Financial Policy

Thank you for choosing our office. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and affordable for our patients as possible by offering several payment options. If you have dental insurance we are here to assist you in receiving your maximum allowable benefits.

We accept cash, personal checks, Mastercard, Visa, American Express, Discover and Care Credit. In addition, we offer an excellent third party financial payment plan. Our office staff would be happy to provide you with more detailed information on this plan if you are interested.

As a courtesy to our patients, we will submit your insurance claims for you. However, it is important to understand that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. We do not provide services on the assumption the charges will be paid by an insurance company. All charges are your responsibility from the date the services are rendered.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Per California law, the patient will be billed the full usual and customary rate for any non-covered services.

You may direct your dental insurance company to pay their share of the cost to our office (Assignment of Benefits). Often, payments for claims submitted to your dental insurance company are not received in a timely manner. We, therefore, request that you pay your estimated share at the time of treatment. Upon receipt of payment from your insurance company, we will reconcile your account. At this time we will send you a bill or a refund for any difference.

We would like to emphasize that as dental care providers, our relationship is with you, the patient, and not your insurance company. While filing insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered.

In an effort to schedule everyone in a timely manner, we ask that you please give us a minimum 24 hour notice if you need to reschedule your appointment. Please see our cancellation/missed appointment policy for details.

All outstanding balances over 90 days will be assessed an 18% service charge.

If you have any questions about our financial policy, please do not hesitate to ask us. We are here to assist you.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date

BACKHUS
FAMILY DENTISTRY

Cancellation and Missed Appointment Policy

We understand that you may sometimes need to reschedule your appointment due to extenuating circumstances. A cancellation made with less than 24 hour notice significantly limits our ability to make the appointment available for another patient in need. As such, we have implemented the following cancellation and missed appointment policy:

Hygienist (Exams, Cleanings, X-rays) $75

Hygienist (Deep cleaning/Root planing) $100

Dr. Mark (All other treatment) $125

1. Please provide our office a 24-hour notice in the event that you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. To avoid the cancellation fee, please contact us by phone, text, email, or leave a message on the answering machine.

2. The cancellation fee is not billable to your insurance.

3. If you are more than 15 minutes late for your appointment, the appointment may need to be rescheduled.

4. As a courtesy, we make reminder calls for appointments one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date

COMMUNICATION CONSENT FORMS

TEXT MESSAGING OR EMAIL

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging and/or email communication regarding your Protected Health Information. Backhus Family Dentistry offers patients the opportunity to communicate by mobile text messaging and/or email communication. Transmitting patient information by mobile text messaging and/or email has a number of risks that patients should consider before granting consent to use mobile text messaging and/or email communication for these purposes. Backhus Family Dentistry will use reasonable means to protect the security and confidentiality of mobile messaging and/or email information sent and received. However, Backhus Family Dentistry cannot guarantee the security and confidentiality of mobile text messaging and/or email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging and/or email communication between Backhus Family Dentistry and myself, and consent to the conditions outlined herein. Any question I may have, have been answered by Backhus Family Dentistry.

( ) I consent and accept the risk in receiving information via mobile text messaging and/or email communication.

Patient's Signature: _____ Date:_____

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FAMILY DENTISTRY

Notice of Privacy Practices

This Notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect September 23, 2013, 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 applicable law. We reserve the right to make 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment:
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:
We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

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 or disclosures permitted by your authorization while it is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email:
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

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 filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services:
We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:
If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law:
We may use or disclose your health information when we are required to do so by law.

Public Health:
We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

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 correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:
We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:
Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

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 contacting our office. 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. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting:
You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. 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 emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

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 satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification:
In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

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.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Mark E. Backhus, D.D.S..
6940 Fair Oaks Boulevard, Suite D
Carmichael, CA 95608
(916) 483-3417

E-mail: drbackhus@gmail.com

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 send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

BACKHUS
FAMILY DENTISTRY

ACKNOWLEDGEMENT 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 Practices

Signature_____Date _____

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I acknowledge that I have received a copy of the
Dental Materials Fact Sheet dated May 2004

Signature_____Date _____