Dr. John A. O'Brien, III

497 West 3RD Street

Sylacauga, AL 35150

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information and I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the exstent that you have taken action relying on the consent.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE SIGNED: _____

List anyone that you wish to have us discuss your private information with incase you are unavailable:

_____

Welcome to the office of

John A. O'Brien, D.M.D.

General Dentistry

Patient's Name _____ Date of Birth _____

Home Address _____
Street

_____
city state zip code

Home Phone _____ Work Phone _____ Ext. _____

Cell # _____ E-mail Address _____

Preferred Method of contact: ☐ Cell ☐ Text ☐ E-mail

Married ☐ Single ☐ Separated ☐ Divorced ☐ Referred By _____

SS# _____

Person Responsible for this account _____

Employment Information

(for responsible party)

Employer Name _____ Occupation _____

Address _____
Street city zip code

Dental Insurance Information

Name of Insured _____ Insured's Birth Date _____
Last First Mi

Insured Social Security # _____

Dental Insurance Carrier _____ ID# _____ Group # _____

Insured's Employer Name: _____

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

If Secondary Insurance:

Name of Insured _____ Insured's Birth Date _____
Last First Mi

Insured Social Security # _____

Dental Insurance Carrier _____ ID# _____ Group # _____

Insured's Employer Name: _____

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

JOHN A. O'BRIEN, III, D.M.D.

497 WEST 3RD STREET
SYLACAUGA, AL 35150
TELEPHONE (256) 249-3884

FINANCIAL POLICY
And
Consent for Services

Thank you for selecting our practice as your dental practice. In order for our practice to render the highest quality dentistry in a positive environment, we offer the following financial guidelines.

All visits will be given a financial estimate prior to treatment. Our policies for payment, along with our financial options are:

1. If you do not have dental insurance, full payment for dental procedures are due at time of service.

2. For treatment amounts over $350.00, we ask for 50% of the fee on the day of preparation and the balance on completion or the delivery date.

3. If you have dental insurance, your copayment for the dental treatment is expected at the time of treatment.

4. For treatment amounts over $350.00 we ask for 50% of the uninsured portion on the day of preparation and the balance on completion or the delivery date.

If you have dental insurance, please understand that all dental services furnished are charged directly to the patient and that you are personally responsible for payment of all dental services. You are responsible to pay any deductible amount, coinsurance, or any other balance not paid by your insurance company at the time of treatment. This office will help you prepare your insurance forms or assist in making collections from your insurance company and will credit any such collections to your account.

As a service to you, we are happy to file your claims on primary and secondary insurances. In the event your insurance carrier has not or will not pay on your behalf within 60 days, it is your responsibility to pay your account and settle disagreements with your insurance company. Our office cannot render services on the assumption that our charges will be paid by an insurance carrier. A service charge of 1.5% per month (18 % per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

In addition to cash, personal check, Mastercard, Visa, or Discover card we also have our financial partners, Care Credit and the Dental Fee Plan, to assist in paying extended financial arrangements. On open accounts, if payment is not received within 90 days, the account will be turned over for collection and the patient hereby agrees to waive any and all rights to claim personal property as exempt from levy under the law of the State of Alabama. Also, the patient agrees to pay an attorney's fees, court costs and any other reasonable costs of collection.

We will honor the estimated fees for dental care for a period of 6 months from the date of the patient examination.

It is your responsibility to notify our office in the event of an address change.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date_____ Relationship to Patient:_____

Signature of patient, parent or guardian

Welcome to the office of
John A. O'Brien D.M.D.
General Dentistry

PATIENT MEDICAL INFORMATION

Patient_____ **Birth Date**_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Rheumatic Fever
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Rheumatism
☐ Arthritis	☐ Head Injuries	☐ Mitral Valve Prolapse	☐ Sinus Problems
☐ Artificial Joints	☐ Heart Attack or Disease	☐ Nervous Disorders	☐ Stomach Problems
☐ Asthma	☐ Heart Murmur	☐ Pacemaker	☐ Stroke
☐ Blood Disease	☐ Hepatitis	☐ Pregnant	☐ Thyroid Disorders
☐ Cancer	☐ High Blood Pressure	☐ Radiation Treatment	☐ Tuberculosis
☐ Diabetes	☐ Jaundice	☐ Respiratory Treatment	☐ Tumors
☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Ulcers	☐ Venereal Disease

If any of the above are marked "yes" please explain fully:_____

_____

Have you been admitted to a hospital or needed emergency care during the past two years?_____
If "yes" please explain:_____

Are you now under the care of a physician?_____ **If "yes" please explain:**_____

_____

Name of physician:_____ **Phone**_____

Are you presently taking any medications?_____ **If so, please list:**_____

_____

Are you allergic to any medications (such as penicillin or codeine)?_____

_____

Have you ever had any complications following dental treatment?_____ **If "yes" please explain:**

_____

Have you ever been premedicated with antibiotics by a dentist before a dental visit due to a certain medical condition?_____

In case of an emergency, notify _____ **Phone**_____

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 your office at the next appointment.

_____ **Date**_____
Signature of patient, parent or guardian

Please Click HERE to Email This to Us