RIDGEWAY
FAMILY DENTISTRY

Dr. Robert J. Bauder, DMD
36297 Kenai Spur Hwy | Soldotna, AK 99669
Phone: (907)262-8404 | Fax: (907)262-9442
Email: ridgeway@mb2dental.com | www.RidgewayFamilyDentistry.com

PATIENT INFORMATION

Patient Name: Preferred:

Date of Birth: Gender: ☐ Male ☐ Female ☐ Other

Family Status: ☐ •Child ☐•Single ☐ •Married ☐ •Other Do you have children? ☐ •Yes ☐ No

Address: City: State: Zip:

Home Phone: Mobile Phone: Work Phone:

E-mail: Employer: Occupation:

Emergency Contact: Relationship to Patient: Phone:

How did you hear about our office?

HEALTH AND DENTAL HISTORY

Previous Dentist: Phone Number:

Estimated Date of Last Dental Visit: Date of Last X-Rays:

How often do you brush? Floss? Do you use an electric toothbrush? ☐ •Yes ☐ •No

Reason for Today's Visit: Are you dissatisfied with your teeth? ☐ •Yes ☐ •No

If Yes, what would you change?

Do you have fear of going to the dentist? •☐ Yes ☐ •No

Do you have any of the following? Check all that apply

☐ •Bad Breath	☐ •Facial Joint Pain	☐ •Lost or Broken Fillings	☐ •Sensitivity to Cold
☐ •Bleeding Gums	☐ •Food Collection Between Teeth	☐ •Other: _____	☐ •Sensitivity to Heat
☐ •Broken Teeth	☐ •Grinding Teeth	☐ •Periodontal Treatment	☐ •Sensitivity to Sweets
☐ •Clicking/Popping Jaw	☐ •Jaw Pain/Tenderness	☐ •Pregnant	☐ •Sensitivity When Biting
☐ •Ear Pain	☐ •Loose Teeth		☐ •Sores in Your Mouth
☐ •Acid Reflux	☐ •Heart Ailment	☐ •Pacemaker	☐ •Ulcer(s)
☐ •Anemia	☐ •Heart Disease	☐ •Persistent Cough	**Allergies**
☐ •Arthritis	☐ •Heart Murmur	☐ •Pre-Med Before Treatment	☐ •Antibiotics: _____
☐ •Artificial Heart Valves	☐ •Hepatitis (Circle One) A B (	☐ •Prolonged Bleeding	☐ •Aspirin
☐ •Artificial Joints	☐ •High Blood Pressure	☐ •Radiation Treatment	☐ •Codeine
☐ •Asthma	☐ •History of Fainting	☐ •Respiratory Problems	☐ •Ibuprofen
☐ •Blood Disease	☐ •History of Snoring	☐ •Rheumatic Fever	☐ •Jewelry Metals
☐ •Cancer	☐ •History of Tobacco Use	☐ •Rheumatism	☐ •Latex
☐ •Chemotherapy	☐ •HIV Positive	☐ •Seizures	☐ •Metals
☐ •Dental Anxiety	☐ •Kidney Disease	☐ •Sinus Problems	☐ •Nitrous Oxide
☐ •Diabetes	☐ •Liver Disease	☐ •Stomach Problems	☐ •Non-Steroidal Anti-Inflammator
☐ •Epilepsy	☐ •Mental Disorders	☐ •Stroke	☐ •Pain Medicine: _____
☐ •Gag Reflex	☐ •Nervous Disorders	☐ •Thyroid Problem	☐ •Penicillin
☐ •Glaucoma	☐ •On Birth Control	☐ •Tumors	☐ •Other: _____

Please list all major surgeries within the last 10 years:

Please list below all medications you are currently taking. If you need an additional sheet please ask.

I hereby certify that all the above information is correct and true to my knowledge:
Patient Signature or Legal Guardian: Date:

Changes: ☐•Yes ☐ •No Initial: Date: Changes: ☐•Yes ☐ •No Initial: Date:

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Ridgeway is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Ridgeway and will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
- Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share health information for certain situations, such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
- Comply with law. We can share information about you if state or federal law requires it, including the Department of Health and Human Services.
- Do research. We can use and share information for health research.
- Family and friends. We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
- Organ and tissue donation requests. We can share information about you to organ procurement organizations.
- Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security).
- Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights; we typically use or share your health information in the following ways:

- Get an electronic or paper copy of your medical information. You have the right to inspect and/or obtain a copy of your medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) of your medical information, we may charge you a reasonable, cost-based fee.
- Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say "yes" to all reasonable requests.
- Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no.
- Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.
- Privacy notice. You can ask and receive a paper copy of this notice at any time.
- Complaint. You can file a complaint if you feel we violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases we will never share your information unless given written permission: Marketing purposes, fundraising, and the sale of information.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you and we determine that, in our professional judgement, your consent to receive treatment is clearly inferred from the circumstances.

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State Law
We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice of Privacy Practices. We will not share your information other than described in here unless we received written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer Thomas Southam by mail at: 36297 Kenai Spur Hwy, Soldotna, AK 99669 or by telephone at 907-262-8404. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I authorize information about treatment, billing, or appointments to be discussed with the following person(s):

_____

_____

☐ I do NOT authorize any information to be discussed with any family members or friends.

I have read and understand the above information in this notice.

_____ _____
(Print First and Last Name) **(Date of Birth)**

_____ _____
(Patient Signature – or Authorized Representative) **(Today's Date)**

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For Office Use Only

The Following Patient or Authorized Representative: _____

☐ Refused to sign the Notice of Privacy Practices because: _____

☐ Was unable to sign the Notice of Privacy Practices because: _____

INSURANCE INFORMATION AND AGREEMENT

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO LET US KNOW WHICH POLICY IS PRIMARY AND SECONDARY COVERAGE IF YOU ARE COVERED BY MORE THAN ONE POLICY.

□ •I do NOT have dental insurance

By checking this box, I acknowledge that I have no dental insurance and that all costs associated with my treatment are my responsibility and will be collected at the time services are rendered.

•□ I have dental insurance

By checking this box, I acknowledge that my insurance is a contract between myself and my insurance company. Ridgeway Family Dentistry is **NOT** a party to this contract, and therefore cannot guarantee what my insurance will cover. **I understand that the staff at Ridgeway Family Dentistry will bill my insurance company as a courtesy to me and that all out of pocket estimates given to me are an estimate and not a guarantee of payment**. **I am aware that this estimated co-pay is due at the time my services are rendered.** It is my insurance company that makes final payment determinations based on my specific insurance plan. I agree to cover any and all costs of the charges not covered by my insurance. It is ultimately my responsibility to know the coverage and limitations of my plan.

Primary Dental Insurance

Policy Holder's Name:		Relationship to Patient:
Date of Birth:	SSN:	Employer:
Insurance Company:		Insurance Phone:
Group Number:		ID Number:

Secondary Dental Insurance

Policy Holder's Name:		Relationship to Patient:
Date of Birth:	SSN:	Employer:
Insurance Company:		Insurance Phone:
Group Number:		ID Number:

Please Note: We accept all major insurance companies, however we are not a preferred provider (PPO) for any insurance company. We also DO NOT accept Medicare, Medicaid or Denali Kid Care.

We Believe In The Right To Choose Your Own Dentist!

Patient Signature or Legal Guardian: **Date:**

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GENERAL CONSENT FOR DENTAL TREATMENT

I understand the purpose of this general consent is to raise my awareness of risks that are common-place in many dental procedures. I understand my dentist reserves the right where appropriate (for example: for root canal therapy, extractions, and other oral surgery, treatment of gum disease, placement or restoration of implants, crowns, bridges, and dentures) to provide me with a more specific informed consent discussion.

I understand that every dental patient has the right to informed consent. That means that as a patient or as a legal guardian for patient I should understand what treatment is being proposed, what the possible complications and risks are, and what the alternatives are to the treatment. Of course, one alternative for me is to do nothing, although that carries with it its own risks. My signature below confirms that I understand that no dental treatment is completely risk free, and that my dentist will take reasonable steps to limit any complications of my treatment and to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity.

For routine fillings, dental cleanings, prescriptions of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medication could have an adverse interaction, and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in a certain percentage of cases patients have had an allergic reaction to the anesthetic, and adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of post-operative infection, nerve damage, and iatrogenic injury (meaning a complication resulting from treatment). In rare cases, the complications from surgery can be permanent, disabling, or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation or breakage of dental instruments which may become lodged in a gum or other soft tissue or aspirated. Should I experience any of these or other conditions during or following treatment, I will contact my dentist as soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or results of treatment or surgery. I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications, and I promise to use that right to its fullest extent if for any reason I feel I am not fully informed about my procedure, the risks of the procedure, and my alternatives to the procedure.

☐ By checking this box, I hereby freely and voluntarily consent to the use of my photograph and/or testimonial to be used to market or advertise Dr. Bauder's dental practice, including the office website.

I have read and understand the above and I have had the opportunity to ask questions.
Patient Signature or Legal Guardian: **Date:**

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OFFICE POLICIES

Welcome to our office and thank you for choosing Ridgeway Family Dentistry to serve all your dental needs! We are dedicated to providing the highest quality dental care and service to our patients. We ask that you take a couple minutes to thoroughly read over our office policies. If you have ***any*** questions, please do not hesitate to ask, we are here to help you in any way we can!

Appointments

Our staff enters all patient information into our electronic health record system and verifies insurance benefits prior to scheduled appointments. This allows for faster check-in at the front desk. Our goal is for patients to see the doctor or hygienist as close to their scheduled time as possible. As a courtesy to patients, if you have not already confirmed electronically, a reminder phone call will be made two business days prior to scheduled appointments, allowing you to cancel without incurring a missed appointment fee. If you will be late to your appointment, please let our office staff know as soon as possible. If you are more than 15 minutes late for your appointment, you will be asked to reschedule or wait until patients that arrived on time have been seen.

We see patients on an appointment basis only. We consider an appointment made to be a commitment between our office and the patient. Our doctors and team are counting on you to be here, on time, as scheduled. We kindly request an advance notice of at least 48 hours if you need to make a change to your reserved appointment time. If you are unable to provide us with advanced notice due to extenuating circumstances we are unaware of, please call us and let us know as soon as possible to avoid any fees. If you are unable to make your appointment and fail to give us advanced notice a $25 fee will be charged to your account. Arriving 15 minutes late to your appointment is considered a late cancellation and is subject to the same fee.

Regular Visits

Regular follow-up care is very important in preventing cavities and maintaining long-lasting dental health. We encourage our patients to return for their recommended visits and will inform you when you are due for your next visit at the end of each appointment. We may contact you via mail, email, text and/or

Emergencies

If you have a dental emergency, please call the office **right away** and we will do everything possible to get you in at the earliest opportunity. If we are out of the office or it is after hours, we have an answering machine with instructions on what to do. Please understand we try to keep your waiting time to a minimum and we know your time is valuable. Sometimes there are circumstances out of our control that dictate a waiting time longer than usual. When this happens we try to give our patients a courtesy call to let them know there may be additional waiting time. Please make sure we have current contact information for you on file so that we may contact you when needed.

Transferring Of Records

You must sign a written request if you want to have copies of your records and/or x-rays sent to another office. By doing this, you authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred to us from another doctor or organization, you authorize us to receive such information.

I have read and understand the *Office Policies* listed above and I have had the opportunity to ask any questions. I agree to comply with the policies above.

Patient Signature or Legal Guardian: **Date:**

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FINANCIAL POLICIES

At Ridgeway Family Dentistry our primary goal is not to allow the cost of treatment prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable. If you do not have dental insurance we have financing options listed in further detail. ***Please let us know immediately if you have any questions after reading this page.***

Our fees are based on the quality of materials we use and the time, effort and skill required in performing your needed treatment. We charge what is the usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve oral health. Ultimately, however, you are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

This is an agreement between Ridgeway Family Dentistry as creditor/practice, and the patient/debtor named on this form. In this agreement the words "you," "your," and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Ridgeway Family Dentistry.

By signing this agreement, you agree to pay for any costs we may estimate due to us prior to services being rendered.

Types of Insurances

Participating or PPO: We are NOT Participating Providers with any insurance companies. Every policy is different and it is each patient's responsibility to be familiar with their insurance coverage and to determine whether or not we are the appropriate provider for their policy.

Non Participating: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, we will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy and to see that your insurance company covers your bill. Failure to obtain the referral and/or preauthorization may result in lower payment or no payment from your insurance company.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement.

Payment Options

Payment for services is due at the time services are rendered unless prior arrangements have been made. Checks that are returned to our office from your financial institution are subject to a $25.00 returned check fee. This fee covers the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at anytime to discuss any concerns you may have.

We accept the following forms of payment:
Cash | Check | Visa | Master Card | Discover | American Express

Estimated amounts not covered by insurance are due the day the treatment is rendered. Any dental insurance claim remaining unpaid 90 days from the date of treatment was rendered will be due immediately from the patient.

If you have dental insurance:

1. You pay your deductible if you have one, and any estimated out of pocket costs the day the treatment is rendered.
2. You choose to pay your treatment in full by cash or credit and have your insurance company send payments on your behalf directly to you.

If you DO NOT have dental insurance:

1. You pay by one of our accepted forms of payment on the day the treatment is rendered.

2. On extensive treatment, you may prefer to secure a bank, credit-union, or other third-party financing for the entire amount and make payments to the lending institution.
3. We offer Care Credit with one year no interest, on approval of credit. Care Credit is a third party lender and is an effective solution for many patients who choose to make payments for their dental care. (Ask the front desk for more information on applying for Care Credit).

NOTE: We DO NOT offer in house monthly payment plans.

Credit Balances And Refunds

Occasionally an insurance company will pay more than we estimated on your behalf. If this occurs we will issue you a refund check. We issue these checks on a monthly basis and it is your responsibility to monitor your explanation of benefits (EOB) from your insurance company to see if there has been an overpayment on your behalf. If you have a credit balance of less than $10.00, it will remain on your account for future treatment unless you contact us otherwise and request a check be issued to you.

Worker's Compensation/Personal Injury

We require full payment up front unless other arrangements have been made prior to your appointment.

Credit History/Waiver of Confidentiality

You give us permission to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. You understand that if this account is submitted to an attorney or collection agency, if we litigate in court, or if your past-due status is reported to a credit reporting agency, that any treatment received at our office may become a matter of public record.

I have read and understand the *Financial Policies* listed above and I have had the opportunity to ask any questions. I agree to comply with the policies above.
Patient Signature or Legal Guardian: **Date:**

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