Welcome!

RACHEL BARNHART D.D.S.

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask and we will be happy to help.

Patient Information

Name _____Birthdate_____SSN_____
Address_____City_____
State_____Zip Code_____Email:_____
Drivers License #: _____ Issuing State: _____

Cell Phone_____ Home Phone_____ Work Phone_____

Check appropriate box: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Parent/Guardian_____
Whom may we thank for referring you?_____
Person to contact in case of emergency?_____

Responsible Party

Name of person responsible for this account_____Relationship_____
If self responsible please skip to **Insurance Information**
Birthdate_____SSN_____ E-Mail_____
Address_____City_____
State_____Zip Code_____
Cell Phone_____ Home Phone_____ Work Phone_____

Insurance Information

Name of insured _____Relationship_____
Birthdate_____ SSN_____
Name of Employer_____
Insurance Company_____
Group #_____
Policy/ID #_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, please complete the following:
Name of insured _____Relationship_____
Birthdate_____ SSN_____
Name of Employer_____Insurance Company_____
Group #_____ Policy/ID #_____

X_____
Signature of patient (or parent/guardian if minor) Date

Please turn over to complete backside

RACHEL BARNHART
D.D.S.

CONSENT FOR USE DISCLOSURE OF HEALTH INFORMATION FOR STATE OF CALIFORNIA HIPAA COMPLIANCE

Patient Name: _____ Date: _____

Address: _____

Telephone: _____ _____ _____
[ ] Home [ ] Mobile [ ] Work

Last 4 of Social Security #: _____ Email: _____

By signing this form, you will consent to our use and disclosure of your health information to carry out treatment, payment activities and healthcare operations on your behalf. You have the right to read our complete Notice of Privacy Practices before you decide whether to sign this consent. You will find the notice post in our lobby and if you would like, we will make you a personal copy. In addition, you have a right to revoke this consent at any time by written notice to our office.

RELEASE OF INFORMATION

It is our policy not to release any information concerning the reason for your visit. If you would like us to be able to speak to family members regarding your healthcare, please complete this form, including the person(s) to whom we may speak.

Name of Person(s): _____
Name Relationship

_____
Name Relationship

_____
Name Relationship

_____
Patient Signature (or Guardian) Date

MEDICAL HISTORY FORM

Patient Name:
DOB:
Date Completed:

RACHEL BARNHART D.D.S.

DOC SIGNATURE/DATE

Primary Care Physician _____Date of Last Exam_____

1. Are you currently under the care of a medical provider (i.e. Cardiologist, Orthopaedic Surgeon, other specialist)? [ ] Yes [ ] No
Name of Specialist(s): Dr. _____; Dr. _____; Dr. _____
2. Have you been told by your doctor that you can't undergo dental treatment? [ ] Yes [ ] No
3. Have you been hospitalized or had any surgical operations within the last 5 years? [ ] Yes [ ] No
If yes, please explain and list dates:

_____ _____
Doctor name procedure date Doctor name procedure date

4. Have you ever had a surgery to correct your airway/breathing including nasal surgery, tonsillectomy, adenoidectomy?
If so, please list surgeries & dates: _____ [ ] Yes [ ] No
5. Have you been told you need to pre-medicate with antibiotics or do you take a sedative prior to invasive dental treatment?
If so, please list why and the medication used:_____ [ ] Yes [ ] No
6. Are you taking any medication(s) including over the counter supplements? [ ] Yes [ ] No
If you answered yes to question no. 6, please list all medications on the attached Medication List (including PAP therapy for sleep apnea).
7. Are you taking Aspirin or any other Blood thinners? (INR if applicable: _____) [ ] Yes [ ] No
8. Have you ever taken Fosamax, Boniva, Actonel, Prolia, any other osteoporosis medications, or any cancer medications containing bisphosphonates? Dates: _____ - _____ (or) presently [ ] Yes [ ] No
9. Have you ever taken Fen-Phen/Redux? [ ] Yes [ ] No
10. Have you taken Viagra, Revatio, Cialis or Levtra in the last 24 hours? [ ] Yes [ ] No
11. Do you use tobacco? [ ] Yes [ ] No
12. Do you use controlled substances? [ ] Yes [ ] No
13. Are you wearing contact lenses? [ ] Yes [ ] No
14. Please list any medication allergies you have and what reaction occurs when taken:
_____
15. Do you have persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? [ ] Yes [ ] No
16. Women Only:
Are you pregnant or think you may be pregnant? # of weeks: _____ [ ] Yes [ ] No
Are you nursing? [ ] Yes [ ] No
Are you taking oral contraceptives? [ ] Yes [ ] No

Do you have or have you had any of the following?

	Y	N		Y	N		Y	N
AIDS/HIV Last CD4 count: _____			Glaucoma			Organ Transplant / Immunosuppression		
Angina / Chest Pains			Hay Fever/ Seasonal Allergies/ Nasal Congestion			Pacemaker		
Anemia / Blood Disorder			Heart Attack / Date(s): *Stent Placed?* Y / N			Radiation Therapy / Chemo location:		
Arthritis			Heart Disease / Heart Trouble			Recent Weight Loss / Gain		
Asthma			Hepatitis A B C			Respiratory Problems / Emphysema/ COPD		
Cancer *In remission? Type:* _____ (circle one) Y / N			High Blood Pressure			Rheumatic Fever		
Mental Health Condition?			List: _____			Other:		

MEDICAL HISTORY FORM

Patient Name:
DOB:
Date Completed:

RACHEL BARNHART D.D.S.

DOC SIGNATURE/DATE

Congenital Heart Defect Infective Endocarditis Artificial Heart Valve Placement	Y	N	Joint Replacement *Complications? Y / N* *Pre-Med? Y / N*	Y	N	Sleep Apnea: *Currently treating? Y / N*	Y	N
Diabetes: Last A1c_____ Type I Type II			Kidney Disease ; stage: _____ Dialysis? Y / N			Stomach Problems / Acid reflux (GERD, LPR)		
Easily Winded / Mouth Breather			Leukemia			Stroke / Date(s): *Stent Placed? Y / N*		
Epilepsy / Convulsions			Liver Disease ; stage: _____			Swollen Ankles		
Fainting / Seizures			Low Blood Pressure			Thyroid Problem / hormonal imbalance		
Frequently Tired			Mitral Valve Prolapse / Heart Murmur			Tuberculosis *If yes, finished treatment?* (circle one) Y / N		

Dental History Previous Dentist: _____ Last Exam: _____

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 near (or in) your mouth?	[ ] Yes	[ ] No
6.	Have you had any head, neck or jaw injuries?	[ ] Yes	[ ] No
7.	Have you ever experienced any problems in your jaw? (ie pain, throbbing, tiredness, "TMD")	[ ] Yes	[ ] No
8.	Do you have frequent headaches?	[ ] Yes	[ ] No
9.	Do you clench or grind your teeth?	[ ] Yes	[ ] No
10.	Do you bite your lips or cheeks frequently?	[ ] Yes	[ ] No
11.	Have you ever had difficult extractions in the past or prolonged bleeding following extractions?	[ ] Yes	[ ] No
12.	Have you ever had habits such as nail biting, thumb/finger sucking, tongue thrusting?	[ ] Yes	[ ] No
13.	Have you had any orthodontic treatment? If yes, when?_____ Orthodontist Name: _____	[ ] Yes	[ ] No
14.	Do you wear dentures or partials?	[ ] Yes	[ ] No
15.	Do you like your smile?	[ ] Yes	[ ] No

Please answer these questions by circling YES or NO:

1.	Do you, or have you been told, you snore?	YES	NO
2.	Do you feel excessively tired or fatigued all the time?	YES	NO
3.	Has anybody observed you holding your breath during sleep?	YES	NO
4.	Do you have or are you being treated for high blood pressure?	YES	NO

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and agree to be responsible for payment of all services rendered on my behalf or my dependents. By signing below, I also consent to be treated at Rachel Barnhart DDS, for any and all dental care.

X_____

Signature of patient (or parent/guardian if minor) Date

RACHEL BARNHART
D.D.S.

2190 Larkspur Lane
Suite 100
Redding, CA 96002

(530) 222-1400 (office)
(530) 222-1484 (fax)

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable California law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address:_____City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:

Rachel Barnhart, D.D.S.

2190 Larkspur Lane, Suite 100, Redding, CA 96002

Phone: 530-222-1400 Fax: 530-222-1484

Specific information to be disclosed:

□ Medical/Dental Record from (insert date) _____ to (insert date) _____

□ Other: _____

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:

Month: _____ Day: _____ Year: _____.

Please email all x-rays/images/etc to: office@rachelbarnhartdds.com (dexis)

SIGNATURE:

Patient/Legal Representative: _____ Date:_____

Patient Name: _____
DOB: _____
Date: _____

RACHEL BARNHART
D.D.S.

2190 Larkspur Lane
Suite 100
Redding, CA 96002

(530) 222-1400 (office)
(530) 222-1484 (fax)

MEDICATION LIST

1. _____
   Name Dosage Frequency Condition
2. _____
   Name Dosage Frequency Condition
3. _____
   Name Dosage Frequency Condition
4. _____
   Name Dosage Frequency Condition
5. _____
   Name Dosage Frequency Condition
6. _____
   Name Dosage Frequency Condition
7. _____
   Name Dosage Frequency Condition
8. _____
   Name Dosage Frequency Condition
9. _____
   Name Dosage Frequency Condition
10. _____
    Name Dosage Frequency Condition

RACHEL BARNHART
D.D.S.

2190 Larkspur Lane #100
Redding, CA 96002
(530) 222-1400

OUR FINANCIAL & CANCELLATION POLICY

Patient Name: _____ Date: _____

Basic Policy:
Payment in full is due at the time service is provided. Our office accepts cash, Visa, Mastercard, Discover, American Express, and personal checks (with a valid driver's license). There is a $50.00 returned check fee due and payable from you for each check returned to us by your bank. If your account becomes seriously delinquent and assigned to a collection agency or referred to an attorney, you may be liable for reasonable collection costs, court costs and attorney fees.

As a service to all our patients, we will bill your insurance carrier, if proper paperwork is provided to us. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company, not between Dr. Barnhart and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

Cancellation Policy:

Dr. Barnhart is committed to providing all of her patients with exceptional care. When a patient cancels, reschedules or no shows without giving enough notice, they prevent another patient from being seen.

Please call us at (530) 222-1400, at least 48 business hours notice prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel/reschedule a *Monday or Tuesday* appointment, please call our office by 12:00 p.m. on *Thursday*.** If prior notification is not given, **you will be charged $50** for the missed/rescheduled appointment.

If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

_____
Patient Signature (or Guardian) Printed Name *(if not patient listed above)*

_____
Relationship to Patient