UPDATE FORM Rev. 2018.09.12

Riverside FAMILY DENTAL

NAME			
Birthdate		SSN	
Phones	Home	Cell	Office

Street		2nd Add. Street	
City/ST/Zip		2nd City/ST/Zip	
Email		Referred by	

☐ Married ☐ Single ☐ Widowed ☐ Other Emergency Contact Phone

Will we be filing dental insurance? ☐**YES** ☐**NO** Does any immediate family member have separate dental insurance? ☐ YES ☐ NO

Please present your cards for all dental insurance, TriCare, and FED to our receptionist to copy!

Insurance Co.		Mbr/Subs ID			
Insured Name		Employer			
Insured DOB		Group Name or #			
Insured SSN		Group Plan		Ins. Phone	

HISTORY Do you have, or have you ever had, any of the following?

	Y	N		Y	N		Y	N		Y	N
AIDS			Drug Addiction			HPV (Human Papilloma Virus)			Respiratory Problems		
Allergies (Seasonal)			Emphysema			Jaundice			Rheumatic Fever		
Anemia			Epilepsy/Convulsions			Jaw Joint Pain			Rheumatism		
Angina or Chest Pain			Excessive Bleeding			Joint Replacement			Scarlet Fever		
Arthritis			Fainting			Kidney Disease			Seizures		
Artificial Heart Valve			Glaucoma			Liver Disease			Shortness of Breath		
Asthma			Heart Condition			Low Blood Pressure			Sinus Problems		
Blood Disease			Heart Lesions (congenital)			Mitral Valve Prolapse			Sleep Apnea		
Bruise Easily			Heart Murmur			Nervousness/Depression			Stomach Problems		
Cancer			Heart Surgery			Nursing			Stroke		
Cervical Cancer			Hepatitis A			Pacemaker			Swelling of Feet/Ankles		
Chemotherapy			Hepatitis B			Persistent Cough			Thyroid Disease		
Cortisone Medication			Hepatitis C			Pregnant			Tuberculosis		
Diabetes			High Blood Pressure			Radiation Therapy			Ulcers		
Dizziness			HIV Positive			Recent Weight Loss			Venereal Diseases (STDs)		

Other – please include recent surgeries:

EPIPEN

	Y	N
EpiPen Rx or use?		

ALLERGIES Are you allergic to, or have you reacted adversely to, any of the following?

	Y	N		Y	N		Y	N		Y	N		Y	N		Y	N
Foods			Food Coloring			Latex			Bites/Stings			Fruit						

MEDICATION ALLERGIES

	Y	N		Y	N		Y	N		Y	N
Barbiturates			Darvon			Nitrous Oxide			Sedatives		
Aspirin			Erythromycin			Penicillin			Steroids		
Codeine			Local Anesthetic			Percodan			Sulfa/Sulfites		

OSTEOPOROSIS MEDICATIONS Have you taken any of the following bisphosphonate medications, even once?

	Y	N		Y	N		Y	N		Y	N		Y	N		Y	N
Actonel			Aredia			Boniva			Fosamax			Reclast			Zometa		

BLOOD THINNERS: Are you currently taking any blood thinners? Y___ N___ If so, what medication?

OTHER MEDICATIONS Include ALL regularly used prescription drugs, dietary supplements, herbals, vitamins, and over-the-counter preparations.

Dose	**Medication** (include those given in-office)	**Taken to treat what condition/symptoms/disease?**

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.

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment - We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

Payment - We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation - We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies - We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health - We may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.

Judicial and Administrative Proceedings. -We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement - We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons - We may disclose your health information to coroners or medical examiners.

Organ Donation - We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research - We may disclose your health information to researches conducting research that has been approved by a Institutional Review Board.

Public Safety - It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies - We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing - We may contact you for marketing purposes or for fund-raising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of practice sponsored fund-raising events."

Change of Ownership. - In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that this practice is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that this practice amend your health information. Please be advised, however, that this practice is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by this practice.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices - This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this Notice.

This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact us.

Complaints - Complaints about your privacy rights, or how this practice has handled your health information should be directed by calling this office. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights * 200 Independence Ave, SW * Room 509F HHH Building * Washington, D.C. 20201

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I _____, have had opportunity to read the Notice of Privacy Practices (posted in reception window) of Riverside Family Dental, PA.

I have reviewed and agree to the Notice of Privacy Practices.

(Check appropriate box) □ Patient □ Parent □ Guardian

Signature _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
Please Print Name	Relationship
_____	_____
Please Print Name	Relationship
_____	_____
Please Print Name	Relationship

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

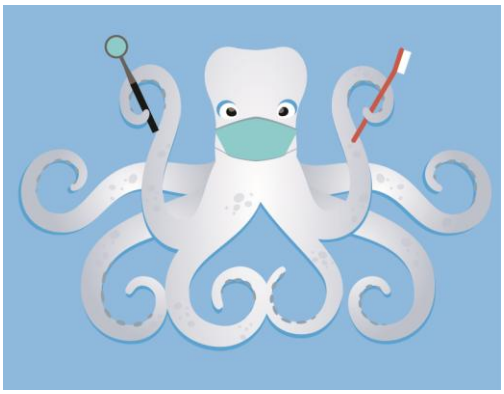
□ *Individual refused to sign*
□*Communications barriers prohibited obtaining it*
□ *An emergency prevented obtaining it*
□*Other(specify):*

_____

_____

Employee signature _____ *Date* _____

Patient Name(print)_____



FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality of dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing, such as Care Credit.

X_____ I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees, in addition to payment of the balance owed for dental services rendered.

Please check if you would like more information about financing options. _____

Please note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges.

Consent:

I have read, understand and agree to the above terms and conditions. If I have insurance, I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

X_____ X_____

Signature (Parent if child) **Date**

Do you have insurance?

- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer (if applicable), and your insurance company. As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you. However, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits and limitations will determine the amount paid.
- We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to determine whether to expect payment from them. If payment is not received or your claim is denied, you will be responsible for paying any remaining balance at that time.
- We strive to provide you the best possible treatment and to estimate your benefits as accurately as possible, based on the information your insurer discloses to us. However, we do NOT allow insurance companies to dictate necessary treatment. We recommend the necessary treatment and provide options based on your individual needs as a result of your clinical examination. We DO try to work with your insurance company to make sure that you receive the benefits provided by your policy.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim, beyond routine appeals.
- We require that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- Patients are responsible for advising us of any changes in their insurer or policy at the time of their visit.

X_____I understand that any insurance estimate is an estimate of benefits based on what the insurance company has stated they MAY pay. I understand I am personally responsible for any amount not paid by my insurance company despite what the estimate states, due to my contractual agreement with my insurance company and any limitations on my individual policy.

X____I understand that payment is due when services are rendered. We ask that you pay the deductible and co-payment, which is the ESTIMATED amount, not covered by your insurance company, by check, cash, credit card, or Care Credit at the time we provide the service to you. Any other arrangements for payment must be made before any treatment begins.

X____I understand that in non-emergency situations, the dental office can request a pre-treatment estimate, which will also require postponed treatment until a response is received. Riverside Family Dental and Holly Hamilton, DMD are not responsible for any additional issues arising from delaying treatment. I am also aware that regardless of the whether the preauthorization is approved, it does not negate the fact that the treatment is needed.

X____I understand that if I choose not to have the dental office preauthorize treatment with my insurer before the procedure, I am responsible for anything the insurance doesn't pay. Please be aware that a pre-treatment estimate is not a guarantee of payment, depending on individual terms with your policy with your insurance company.

X_____ X_____

Signature (Parent if child) Date

Riverside Family Dental, P.A. **Dr. Holly Hamilton, DMD**
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Phone (772)589-1140 • Fax (772)589-5286 • RiversideFamilyDentalFL@yahoo.com

FRAGRANCE POLICY

Due to staff allergies, please refrain from wearing perfume or cologne to our office. Thank you!

APPOINTMENT CANCELLATION / MISSED APPOINTMENTS POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy**. When an appointment is scheduled, that time has been set aside for you and when it is cancelled or missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give the office **at least 24 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $35 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $35 cancellation fee may be charged. Patients that miss more than one appointment or consistently cancel appointments within the 24 hours may not be rescheduled and may be dismissed from the practice. We do know that some emergencies do occur so if something does happen, please contact us right away!

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

We thank you for trusting your teeth to our care and look forward to a long term relationship in helping to meet your dental needs.

I have read and understand the Appointment Cancellation Policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

I _____ (print name), have reviewed this copy of Riverside Family Dental's Appointment Cancellation Policy.

_____ _____

Signature of Patient **Date**