HIPAA Notice of Privacy Practices

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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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Responsible Party Information

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security # _____ Birth Date: _____

Phone (Home) _____ (Work) _____ Ext.: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID# : _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip code

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

Insurance Plan Name and Address: _____

_____
City State Zip code

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID# : _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

Financial Policy / Consent for Services

It is our policy that billing procedures be clearly understood prior to the onset of treatment. Payment is expected at the time of treatment. Payment will be made by cash, personal check or credit card. Extended payments may be available through prior financial arrangements with our office manager. Any balance reflected is due within 10 days of receipt of your statement. Monthly bookeeping fees may be applied to unpaid balance. If you have dental insurance we will bill your primary insuance company, as a courtesy to you. Complete insurance information must be provided at the time of your first visit. All deductables and co-payments are due at the time of treatment. Please note that dental insurance is designed to help pay part of the cost of treatment. Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated and we cannot guarantee payment of these claims. We will be glad to assist you in filing for these benefits, but you are ultimately responsible for your treatment.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

If you are unable to keep your appointment, please call us as soon as possible or leave us a message if the office is closed. A fee is assesd for missed/broken appointments without 24 hour notice.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

In the event that it becomes necessary to place an account in collection, the patient is responsible for any legal and collection related costs that may be incurred. By signing below you indicate that you have read the proceeding and understand that dental services are rendered in accordance with these terms.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the patient whose name appears on this Health History form, to administer any treatment; or to administer any anesthetics; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

"All services are rendered and accepted under the terms and conditions herein."

_____ _____ _____
Signature of Patient, Parent or Guardian Date Relationship to Patient

Patient Medical History

Physician:_____ Office Phone: _____

1. Are you in good health?..... YES NO
2. Date of last physical examination _____
3. Are you now under the care of a physician?..... YES NO
   If so, what is the condition being treated?_____
4. Have you ever had any serious illness or operation?..... YES NO
   If so, what illness or operation?_____
5. Have you ever been hospitalized?..... YES NO
   If so what was the problem?_____
6. Have you ever had a blood transfusion?.....YES NO
   If so, when_____
7. Have you ever had heart surgery?.....YES NO
8. Do you wear a Cardiac Pacemaker or Defibrilator?..... YES NO
9. Have you ever been asked to premedicate before dental precedures?..... YES NO
10. Have you had joint replacement or pins placed?..... YES NO
    If so, how long ago?_____
11. Have you ever taken any medication considered a bisphosphonate (such as Aredia, Pamidronate, Zometa, Zoledronic Acid, Fosamax, Alendronate Sodium, Actonel, Risedronate Sodium, Boniva or Ibandronate Sodium)?..... YES NO
12. Do you have, or have you had herpes?.....YES NO
13. (Women) Are you pregnant? If so, how many months?.....YES NO
14. Do you have, or have you had any of the following: Please check known conditions?..... YES NO

- ☐ Anemia
- ☐ Heart Ailments
- ☐ High Blood Pressure
- ☐ Respiratory Disease
- ☐ Tuberculosis
- ☐ Nervous Disorders
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Rheumatic fever
- ☐ Blood Diseases
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Kidney Disease
- ☐ Tumors or Growths
- ☐ Radiation treatment of any kind
- ☐ Allergies
- ☐ Asthma or Hay Fever
- ☐ Fainting Spells or Seizures
- ☐ Sinus trouble
- ☐ Rheumatism or Arthritis
- ☐ Head Injuries
- ☐ Stomach Ulcers
- ☐ Venereal Disease/ STD
- ☐ HIV/ Aids
- ☐ Other_____
- ☐ Epilepsy
- ☐ Mental Disorders / Depression
- ☐ Stroke
- ☐ Glaucoma

15. Are you sensitive or allergic to any drugs?..... YES NO
    ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Latex
    ☐ Barbiturates, sedatives or sleeping pills ☐ Codeine ☐ Iodine
    ☐ Other If other. what drugs?_____
16. Are you taking any drugs or medicine?..... YES NO
    ☐ Antibiotics ☐ Anticoagulants ☐ Antihistamines ☐ Aspirin ☐ Blood pressure medicine ☐ Digitalis
    ☐ Cortisone (steroids) ☐ Insulin ☐ Nitroglycerine ☐ Oral contraceptive/ hormonal therapy ☐ Tranquilizers
    ☐ Other If other, what drugs?_____

- Do you have any health problems that need further clarification?..... YES NO

If yes, please exlplain: _____

_____

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 the doctors at the next appointment without fail.

_____

Signature of Patient, Parent, of Guardian Date

Changes in Health _____ Date _____

Changes in Health _____ Date _____

Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please print and fill out these forms completely in ink. If you have questions or need assistance, please ask us and we will be happy to help. Please bring these completed forms wth you to your appointment.

Patient Information
(Confidential)

Name: _____ Date _____

SS: _____ Birth Date: _____ Home Phone: _____

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

Email: _____ Cell Phone: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married

Patient or Parent/Guardian's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

If student, Name of School / College: _____ City: _____ State: _____ Full Time ____ Part Time ____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Anytime ☐ M ☐ T ☐ TH ☐ F

Best number to contact you: _____ Best number to confirm appointment: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____

Patient Dental History

Name of Previous Dentist: _____ Location: _____

1. Have you ever had a local anesthetic (Novacaine, etc.)? ..... YES NO
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... YES NO
3. Have you had any serious trouble associated with any previous dental treatment? ..... YES NO
   If so, explain _____
4. Is there a sensitivity in your mouth to: ☐ Heat ☐ Sweets ☐ Chewing ☐ Cold.... YES NO
   ☐ Biting ☐ Previous Injury
5. Do you feel pain to any of your teeth? ..... YES NO
6. Do your gums bleed while brushing or flossing? ..... YES NO
7. Do you clench or grind your teeth? ..... YES NO
8. Have you ever had any problems in opening your mouth wide? ..... YES NO
9. How long since your last dental treatment? ..... YES NO
10. How long since your last full mouth X-ray? _____
11. Does dental treatment make you nervous? _____ YES NO
    If yes, check ✔ ☐ Slightly ☐ Moderatly ☐ Extremely
12. Do you like your smile? ..... YES NO

IF PATIENT IS A CHILD:

Check ✔ If yes: ☐ Is this the child's first dental visit? ☐ Is the child worried? ☐ Thumb sucking?