Today's Date: (MM/DD/YEAR) ____/____/20____

Circle One: Dr.| Mr.| Mrs.| Ms.| Miss.
First: _____Middle: _____ Last: _____ Jr. | Sr.
Street:_____ City:_____ State: _____Zip: _____
Home Phone: _____Work Phone:_____ Cell Phone:_____
Email Address:_____ May we Contact you by Email? (Circle) **Yes | No**
Social Security #_____Date of Birth: _____ Sex: (Circle) **M | F**
Emergency Contact Name:_____
Emergency Contact Number:_____ Phone:_____
Physician's Name:_____ Physician's Phone:_____

How did you hear about us (check multiple boxes if necessary)?
□ Mailer □ Google □ Friends/Family □ Insurance □ Internet □ Yellow Pages □ Other_____

Insurance Information
Do you have Dental Insurance? □ **Yes |** □ **No**

Primary Insurance			
Subscriber Name		Employer Name	
Subscriber SSN		Employer Phone	
Date of Birth		Insurance Company	
Relation to the Subscriber	□ Self □ Spouse □ Child □ Others	Insurance Group # Insurance Phone #	
Please present your Insurance Card and Driver's License to the receptionist to be photocopied*			
Secondary Insurance			
Subscriber Name		Employer Name	
Subscriber SSN		Employer Phone	
Date of Birth		Insurance Company	
Relation to the Subscriber	□ Self □ Spouse □ Child □ Others	Insurance Group # Insurance Phone #	
Please present your Insurance Card and Driver's License to the receptionist to be photocopied*			

SIGNATURE OF PATIENT, PARENT or GUARDIAN

_____Date:_____

Medical History

Are you under physician's care now? ☐Yes ☐No
Have you ever been hospitalized or had a major operation? ☐Yes ☐No
Have you ever had a serious head or neck injury? ☐Yes ☐No
Are you taking any medications, pills, or drugs? ☐Yes ☐No

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No
Are you on a special diet? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No

Women: Are you:
Pregnant/Trying to be pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, Please explain: _____

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

AIDS/HIV Positive	❑ Yes	❑ No	Leukemia	❑ Yes	❑ No
Cortisone Medicine	❑ Yes	❑ No	Blood Transfusion	❑ Yes	❑ No
Hemophilia	❑ Yes	❑ No	Frequent Diarrhea	❑ Yes	❑ No
Renal Dialysis	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No
Alzheimer's Disease	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Breathing Disease	❑ Yes	❑ No
Hepatitis A	❑ Yes	❑ No	Frequent Headaches	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No
Anaphylaxis	❑ Yes	❑ No	Swelling of Limbs	❑ Yes	❑ No
Drug Addiction	❑ Yes	❑ No	Bruise Easily	❑ Yes	❑ No
Hepatitis B and C	❑ Yes	❑ No	Genital Herpes	❑ Yes	❑ No
Rheumatism	❑ Yes	❑ No	Lung Disease	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Easily Winded	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Herpes	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Chemotherapy	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Hay Fever	❑ Yes	❑ No
Shingles	❑ Yes	❑ No	Pain in Jaw Joints	❑ Yes	❑ No
Arthritis/Gout	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Epilepsy or Seizure	❑ Yes	❑ No	Chest Pains	❑ Yes	❑ No
Hives or Rash	❑ Yes	❑ No	Heart Attack/Failure	❑ Yes	❑ No
Sickle Cell Disease	❑ Yes	❑ No	Parathyroid Disease	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Tumors or Growths	❑ Yes	❑ No
Excessive Bleeding	❑ Yes	❑ No	Cold Sores/Fever Blisters	❑ Yes	❑ No
Hypoglycemia	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Sinus Trouble	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No
Artificial Joint	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No	Congenital Heart Disorder	❑ Yes	❑ No
Spina Bifida	❑ Yes	❑ No	Heart Pacemaker	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Heart Trouble/Disease	❑ Yes	❑ No
Fainting Spells/Dizziness	❑ Yes	❑ No	Convulsions	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	Radiation Treatments	❑ Yes	❑ No
Stomach/Intestinal disease	❑ Yes	❑ No	Recent Weight Loss	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	Yellow Jaundice	❑ Yes	❑ No
Frequent Cough	❑ Yes	❑ No			

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain: _____

List Medications: 1._____ 4._____
Correct Name/Dose 2._____ 5._____
3._____ 6._____

Are you taking: ☐ Blood Thinner (Coumadin/Plavix/Other)
☐ Immunosuppressant
Orthopedic Surgery: ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to me (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN

Signature_____Date:_____
Printed Name_____Date:_____
Dentist Signature:_____Date:_____

Office Policies

We are committed to providing you with the highest level of care at our dental center. Your clear understanding of our office policies is important to our professional relationship. If you have any questions regarding any of our policies below, please ask one of our representatives for further clarification.

Insurance Information & Estimates

- We must have your insurance information a minimum of 48 hours prior to your appointment. This will ensure we can provide you with estimations of your dental services.
- If you have a change in insurance coverage, you need to inform our office 48 hours prior to any appointment.
- All insurance estimates are still the patients' responsibility. If our estimates are inaccurate due to any reason, the patient is still responsible for that portion.
- You have the option to ask for a pre-authorization from your insurance company. This process can take up to 8 weeks and it is still not a guarantee of payment. Any portion that the insurance company does not cover is still the responsibility of the patient.
- Insurance companies can downgrade or deny service at their discretion. Any money owed for services that are not covered due to this will be the responsibility of the patient.
- We will file to your primary and secondary insurance plan. We cannot file insurance to more than two companies. (This includes all medical policies)
- All patient portions are due prior to receiving any services at our dental center. The patient will owe any portion that is not covered by insurance as soon as the insurance company issues an "Explanation of Benefits" (EOB).
- The patient is responsible for monitoring the amount of his / her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by us regarding his / her remaining benefits in any such benefit period. Any money owed for services that are denied due to insufficient insurance benefits, is the patients responsibility.
- The patient is responsible for knowing the active / inactive status of their insurance plan. The patient may not rely upon any information provided by us regarding the active / inactive status of any insurance plan. Any money owed for services that are denied due to an inactive status of the patients insurance benefits, is the patients responsibility.
- Sedation is not covered by insurance in conjunction with any other dental services, even if administered by an anesthesiologist or your dentist; this includes medical insurances as well

Patient / Family Balance

- All patient balances are due before any services are performed. This includes any prior balances that the patient may have incurred from previous services.
- If any immediate family member of a patient has a balance that is over 90 days old, then the entire balance needs to be paid in full before we see the patient or any immediate members in their family.
- If any immediate family member of a patient has a balance that is over $1000.00, then the entire balance needs to be paid in full before we see the patient or any immediate members in their family.

Refunds

- If the patient has a credit on their account for any reason, we will leave this credit on their account and will be applied towards future dental services. If the patient prefers for us to send them a check for the credit balance, it is their responsibility to contact our office and request a refund. Refunds take up to 30 days to be issued to patients.

Appointments

- All reserved appointments **Must be confirmed** within 1 week of the reserved appointment time. If the patient does not confirm this appointment within 1 week of the appointment time, we will **cancel** the appointment. In order to make this communication convenient, **the patient needs to provide us with their email and cell phone number.** We take the personal information of our patients seriously and the email and cell phone numbers are only used to contact our patients regarding their reserved appointments.
- If the patient plans to change / cancel their reserved appointment time **we require a notice of 2 business days**. By giving us enough notice, it will ensure that we can still provide the patient with the most convenient times to see our doctors.

Appointment Deposits

- If we do not receive proper notice to change / cancel a reserved appointment, we may request a $100 non-refundable deposit in order to reserve another appointment time. If there have been multiple instances where a patient does not give proper notice to change / cancel their reserved appointment, we may dismiss the patient from the practice.
- All Root Canal appointments with an Endodontist require a $100 non-refundable deposit. We require 2 business days notice to change / cancel any reserved Root Canal appointments. If a Root Canal appointment is changed or cancelled for any reason without providing the required notice, the patient will forfeit the $100 deposit.
- All Sedation appointments with an Oral Surgeon or an Anesthesiologist require full payment non-refundable deposit at the time the appointment is reserved. We require 3 business days notice to change / cancel any reserved Sedation appointments. If a Sedation appointment is changed or cancelled for any reason without providing the required notice, the patient will forfeit the full payment deposit.
- If treatment is cancelled less than 72 hours prior to your appointment, the fees are non-refundable when IV sedation is planned, and $100 fee will apply if Oral Sedation is planned

General Office Policies

- A parent or legal guardian must accompany all minors.
- All Adults must provide us with a government issued photo ID prior at their appointment.
- Some of the health care professionals performing services in this facility are independent contractors and are not employees of this facility. Independent contractors are responsible for their own actions and this facility shall not be liable for the acts or omissions of any such independent contractors.

----------Please Sign Below----------

I have read a copy of this office's Notice of Privacy Practices **AND** have read the policies of this dental practice and fully agree to all the terms listed.

Patient Name _____

Signature of Patient/Parent/Guardian Party _____ **Date** _____ **Printed name of Parent/Guardian** _____

Notice of Patient Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 3/2013)

Understanding your health record/information: What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others. Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:

- A basis for planning your care and treatment
- A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the Internet or text message when deemed necessary by the healthcare provider.
- A legal document describing the care we provided to you
- A record that you or a third-party payer can verify services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this county, state and the nation
- A tool which we can assess and continually work to improve the care we render and the outcomes we achieve
- To provide you with information on additional treatment alternatives and other health related benefits
- We may use your information for appointment reminders as defined by the "Consent" page

Your Health Information Rights:

Although your health record is the physical property of this practice, the information belongs to you. You have the right to:

- Obtain a copy of this "Notice of Patient Information Privacy Practices"
- Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)
- Amend your health record as provided in 45 CFR 164.524 (HIPAA)
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken
- You have a right to opt out of communications for fund raising activities of this practice

Our Responsibilities, we are required to:

- Maintain the privacy of your health information as defined by federal/state laws
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Notify you of a breach of your protected healthcare information
- Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".

To Report a Problem

If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Treatment, Payment and Health Operations:

Treatment: Information obtained by a member of our healthcare team will be recorded in your record. It will also be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Healthcare Operations: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information may be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the business associate to protect your health information just as we do. Therefore, this practice requires the business associate, their agents, subcontractors and representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)

Communication with family: Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care, as governed by federal/state law.

Research: We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may use or disclose your PHI as required by law or required by a court ordered subpoena.

Abuse and Domestic Violence: As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.

Authorization: We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.