Collins Family Dentistry
Kyle B. Collins D.M.D.
301 E Ash Street
Caldwell, ID 83605

Date:___________________________

PATIENT NAME:____
Birthdate:_____________________
Address:____
City, State, Zip:____
Home Phone:____________________Work Phone:___________________________Cell Phone:_____________
E-mail:____
Whom may we thank for referring you to our office?____

Responsible Party (if someone other than patient)
First Name:____Last Name:______________________________
Address:____
City, State, Zip:____
Home Phone:_________________________ Cell Phone:____
Birthdate:______________________________Soc. Sec:____
E-mail:____

Employer:____Phone:____________________
Address:____
City, State, Zip:____

Receipt of Notice of Privacy Practices: Written Acknowledgement Form

I acknowledge I have had the opportunity to read the Notice of Privacy Practices of Collins Family Dentistry and a copy was made available to me.

____Date_________________________
Signature of Patient or Personal Representative

If Personal Representative's signature appears above, please describe relationship to patient:________________

Patient Name:____ Patient Birthdate_____________________

FINANCIAL POLICY

Before seeing Doctor, please tell office staff if you need to make financial arrangements. In accordance with the Federal-Truth-In-Lending Act, which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies, which apply in this office. The responsible party agrees to the following:

1. Payment in full of all fees the date of treatment by check or cash with a 5% discount.
2. Master Card or Visa is accepted, no discount given.
3. Financing Available through Care Credit.
4. Insurance will be billed for you; all amounts not paid within 45 days or denied by the insurance company are your responsibility and must be paid immediately.
5. I am aware that any account balance not paid within 30 days from the date of first billing, will be accessed a finance charge of 1.5% per month on the unpaid balance (annual rate of 18%).

Responsible Party Signature____Date___________________________

Collins Adult Medical History

Patient Name:____Date:________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following? Please Circle any that apply.

Aspirin Penicillin Codeine Acrylic Latex Sulfa Drugs Local Anesthetics

Others
Allergies:____

Women: Are you……. Please Circle any that apply.

Pregnant/Trying to get pregnant Nursing Taking contraceptives

Are you under a physician's care now? ____

Have you ever been hospitalized or had a major
operation?____

Do you take or have you taken, Phen-Fen or Redux?____

Have you ever taken Fosamax, Boniva, Actonel, Methrotrexate or any other bisphosphonates?_____________________

Are you on a special diet?____

Do you take vitamins, alternative or herbal medicines?____

Do you use tobacco? If yes how much and how often?____

Do you use controlled substances?____

Allergies:

Are you allergic to any of the following types of Metal? Please circle all that apply.

Gold Silver Nickel Others____

Blood Thinners:

Are you currently on coumadin, warfarin or any other blood thinner? ____

Please indicate why you are taking.____

Continued

Do you have, or have you had any of the following? Please circle all that apply.

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B, C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Convulsions	Heart Pacemaker	Parathyroid Disease	Ulcers
Yellow Jaundice	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

Have you ever had any serious illness not listed above?____

____.

Please list current medications: ____

____.

____

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 my (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:____

Date:____

Collins Dental History

Patient Name:____

Who was your last
Dentist?____

Date of your last exam, cleaning______________________________________

Date of your last x-rays____

Do you have sores inside your mouth Yes No

Any history of bleeding gums? Yes No

Have you ever had a jaw or mouth injury? Yes No

____

Are you have any discomfort or pain? Yes No

____

Are you aware of any dental problems? Yes No

____

Have you ever fainted or become nauseous during dental treatment? Yes No

____

Have you ever experienced any illness or complications following dental treatment of any kind?

Yes No

INSURANCE INFORMATION

Person Responsible for Acct:______________________________

Address______________________________

City______________________________State__________Zip__________

Phone______________Birthday__________SS#______________

PRIMARY INSURANCE INFORMATION

Subscriber______________________________SSN______________

Insurance ID Number ______________________________Birthdate______________

Employer Name______________________________

Address______________________________

City______________________________State__________Zip__________

Insurance Company Name______________________________

Address______________________________

Group #______________________________Phone______________

SECONDARY INSURANCE INFORMATION

Subscriber______________________________SSN______________

Insurance ID Number______________________________Birthdate______________

Employer Name______________________________

Address______________________________

City______________________________State__________Zip__________

Insurance Company Name______________________________

Address______________________________

Group #______________________________Phone______________

Dependent Children Covered:

Name/Birthdate______________________Name/Birthdate______________________

Name/Birthdate______________________Name/Birthdate______________________

Release of Information Authorization:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and for dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits to the insurance carrier for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. This authorization may be revoked by written notice by the covered person/employee to the dentist and or to the insurance company.

Authorized Signature______________________________Date______________

Assignment of Benefit Authorization:

I hereby agree that the insurance carrier shall pay Collins Family Dentistry any dental care benefits to which I may be entitled and I assign all of my rights, title and interests in such benefits to Dr. Collins for:

____All services Performed today and in the future. ____Date of Service Only

____Course of the Treatment Plan Beginning______________Ending______________

Authorized Signature______________________________Date______________

Benefits:

Deductible______________Preventative______________Basic______________Major__

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

COLLINS FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you

request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.