DENTAL REGISTRATION FORM

PATIENT INFORMATION

DATE_____ NAME_____/_____
(FIRST) (LAST) (NICKNAME YOU PREFER)

ADDRESS_____
(STREET) (CITY) (APT/UNIT#) (STATE) (ZIP)

HOME PHONE_____ CELL PHONE_____ WORK #_____ EXT_____

EMAIL_____ DOB____/____/____ SEX: M____F____ SS#_____

MARITAL STATUS: M____S____W____D____SEPARATED____PARTNERED____OTHER_____

OCCUPATION_____ EMPLOYER OR SCHOOL_____

EMPLOYER/SCHOOL ADDRESS_____ IF STUDENT, ARE YOU: FT____PT____

SPOUSE'S NAME_____ SPOUSE DOB____/____/____ SPOUSE EMPLOYER_____

EMERGENCY CONTACT_____
(NAME) (ADDRESS) (PHONE)

DENTAL INSURANCE

POLICYHOLDER INFORMATION

POLICYHOLDER NAME_____ DOB____/____/____ EMPLOYER_____

SS# OR INS ID #_____ RELATIONSHIP TO POLICYHOLDER_____/_____/_____/_____/_____/_____
(SELF) (CHILD) (SPOUSE) (PARTNER) (OTHER)

INSURANCE CO NAME_____ PHONE#_____ GROUP#_____

SECONDARY DENTAL INSURANCE (if applicable)
POLICYHOLDER/SUBSCRIBER INFORMATION

NAME_____ DOB____/____/____ EMPLOYER_____

SS# OR INS ID #_____ RELATIONSHIP TO SUBSCRIBER_____/_____/_____/_____/_____/_____
(SELF) (CHILD) (SPOUSE) (PARTNER) (OTHER)

INSURANCE CO NAME_____ PHONE#_____ GROUP#_____

ACCOUNT INFORMATION *(if different from patient information)*

RESPONSIBLE PARTY NAME_____ PHONE #_____

DOB____/____/____ SEX: M____F____ SS#_____

ADDRESS_____
(STREET) (CITY) (APT/UNIT#) (STATE) (ZIP)

I authorize Dr. Riegel and staff to use my health care information and may disclose such information to my Insurance Company(ies) or other pertinent payers or medical facilities and their agents for the purpose of obtaining payment for services, determining insurance benefits or benefits payable for related services and for expanded or continuation of care with other medical facilities and their staff.
I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Dr. Mark Riegel all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____/_____/_____/_____/_____/_____/_____
PRINT PATIENT NAME PATIENT SIGNATURE (or responsible party) DATE (SELF) (GUARD) (PARENT) (POA)
(RELATIONSHIP TO PATIENT)

WHO MAY WE THANK FOR REFERRING YOU?_____

PLEASE TURN OVER TO COMPLETE

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine). Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes_____No_____

Place a mark on "yes" to indicate if you have had any of the following: If none apply, please initial to indicate you reviewed this health history: _____ (initials)

Aids/HIV	☐ Yes	Epilepsy	☐ Yes	Respiratory Disease	☐ Yes
Anemia	☐ Yes	Fainting or dizziness	☐ Yes	Rheumatic Fever	☐ Yes
Arthritis, Rheumatism	☐ Yes	Glaucoma	☐ Yes	Scarlet Fever	☐ Yes
Artificial Heart Valves	☐ Yes	Headaches	☐ Yes	Shortness of Breath	☐ Yes
Artificial Joints	☐ Yes	Heart Murmur	☐ Yes	Sinus Trouble	☐ Yes
Asthma	☐ Yes	Heart Problems	☐ Yes	Skin Rash	☐ Yes
Back Problems	☐ Yes	Hepatitis Type _____	☐ Yes	Special Diet	☐ Yes
Bleeding abnormally, with Extractions or surgery	☐ Yes	Herpes	☐ Yes	Stroke	☐ Yes
		High Blood Pressure	☐ Yes	Swollen Feet or Ankles	☐ Yes
Blood Disease	☐ Yes	Jaundice	☐ Yes	Swollen Neck Glands	☐ Yes
Cancer	☐ Yes	Jaw Pain	☐ Yes	Thyroid Problems	☐ Yes
Chemical Dependency	☐ Yes	Kidney Disease	☐ Yes	Tonsillitis	☐ Yes
Chemotherapy	☐ Yes	Liver Disease	☐ Yes	Tuberculosis	☐ Yes
Circulatory Problems	☐ Yes	Low Blood Pressure	☐ Yes	Tumor or growth on head or neck	☐ Yes
Congenital Heart Lesions	☐ Yes	Mitral Valve Prolapse	☐ Yes		
CortisoneTreatments	☐ Yes	Nervous Problems	☐ Yes	Ulcer	☐ Yes
Cough, persistent or bloody	☐ Yes	Pacemaker	☐ Yes	Venereal Disease	☐ Yes
		Psychiatric Care	☐ Yes	Weight loss, unexplained	☐ Yes
Diabetes	☐ Yes	Radiation Treatment	☐ Yes	Sleep Apnea/Snoring	☐ Yes
Emphysema	☐ Yes	Tobacco Use Type: _____	☐ Yes	Grinding Teeth/Bruxism	☐ Yes

OTHER_____

Do you wear contact lenses ☐ Yes ☐ No

Women:

Are you pregnant: ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name_____

Address_____

Phone_____

ALLERGIES

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____

_____

_____

_____

_____

MEDICAL HISTORY UPDATES (FOR FUTURE USE)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

TEMPORARY INFORMATION INTAKE

ONCE WE HAVE INPUT THIS INFORMATION INTO OUR COMPUTER, THIS SHEET WILL BE SHREDDED

PATIENT NAME: _____

PATIENT SS# _____

PRIMARY INSURANCE POLICYHOLDER SS# OR ALTERNATER ID#: _____

SECONDARY INSURANCE INFO IN APPICABLE

SECONDARY INSURANCE POLICYHOLDER SS# OR ALERNATE ID#: _____

Mark Riegel DMD
Family Dentistry

Park Center, Suite 104
8795 Ralston Road ▪ Arvada, CO 80002
t: 303.424.2222 ▪ f: 303.423.2066
Dr.Riegel@gmail.com
www.MarkRiegelDMD.com

GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.

2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.

3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.

4. **Sensitivity in teeth or gums, infection or bleeding.**

5. **Swallowing or inhaling small objects.**

6. **Concerning Dental extractions:** Risks of post-op infection, pain, dry socket, delayed healing, broken root tip, and paresthesia.

While we follow procedural guidelines that most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

I have read and understand the statements on this page:

_____

Print Patient Name

_____ _____

Patient's **Signature** (Responsible Party if minor patient) **Date**

Mark Riegel DMD, Family Dentistry
8795 Ralston Rd. #104
Arvada, CO 80002

FINANCIAL POLICY

Payment is due at the time services are rendered. We accept Cash, Check, Visa, MasterCard and Discover. When financing is needed we accept Care Credit (medical credit card with interest free options).

Please remember that we bill your insurance as a courtesy and any unpaid balances are your responsibility. Insurance plans are a contract between yourself and the insurance company. We are not a party to that contract. We do our best to estimate what your insurance will pay but we cannot guarantee exact amounts. And we are more than happy to make every effort to help maximize your benefits and collect for you.

Please discuss any questions or concerns with us openly in order to avoid any misunderstandings. We value your patronage and friendship.

CANCELLATION POLICY

If you are unable to keep an appointment, we kindly ask you provide us with **48 hours notice**. This courtesy on your part allows us to give your appointment to another patient. No Show appointments or less than 24 hour cancellations will be subject to a **$40 charge**. More than 3 consecutive cancellations will also be subject to **a $40 charge**.

As a courtesy to all, please refrain from cell phone use particularly beyond the waiting room.

REFERRALS

If you feel we have helped you and wish to refer us to your family and friends we will reward you with gift cards for coffee, dinner, or a movie.

I have read, understand and agree to the above policy:

_____

Print Patient Name

_____ _____

Signature (Responsible party if patient is a minor) Date

WE LOOK FORWARD TO A LONG AND HEALTHY PARTNERSHIP WITH YOU!!

Mark A. Riegel, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices: (attached)

Please Print PATIENT Name

Patient Signature (PARENT Signature if MINOR)

Date

For 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 the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

Mark Riegel DMD Family Dentistry

Please keep this for your records.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 1.1.2015, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. *However, if we are unable to contact you using the ways or* locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Mark Riegel

Telephone: 303-424-2222

Fax: 303-423-2066

Address: 8795 Ralston Road, Suite 104, Arvada, CO 80002

E-mail: markriegeldmd@gmail.com