TIME DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Social Security

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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:

X Date:_____

Informed Consent For General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentost. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are awknowleding your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist;s advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist you may increase teh chances of a poor outcome.

Please read and initial the items below and sign the bottom of the form.

1. Treatment to be provided

I understand that during my course of treatment that the following care may be provided:

Examinations Preventive Services Restorations

Crowns Bridges Other Patient Initials

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction). Patient Initials

3. Changes in Treatment Plan

I understand that during treatment it may necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy ollowing routine restorative procedures. I give my permission to the dentist to make and/all changes and additions as necessary. Patient Initials

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided if applicable. Patient initials

Patient signature Date

Financial Policy

NLP

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. To help you understand our office and financial policies, please read and initial the following prior to seeing the doctor and beginning any treatment.

Insurance

Your insurance elgibility and benefits will be verified prior to your first visit. For your convenience, an **ESTIMATED** quote based on your remaining individual insurance calendar year maximum will be provided. In the event we over- or under- estimate your quote due to information provided to us by your insurance carrier, you may be owed a refund, or may have balance due. We will send any balance information to you by mial. Any refund that may be due will be issued only at the completion of treatment. **Any balance not paid by insurance is determined to be your resposibility.** Any information provided to us prior to treatment is not a guarantee of payment and if any claim is rejected by your insurance carrier, you are responsible for payment of all fees for services rendered. In the event that your carrier has not made payment within 45 days, your outstanding balance will automatically be transferred over to you. Please understand your insurance policy is a contract between you and the carrier. We are not a party to that contract; therefore, it is important for you to be involved to help assure timely payments to your account.

Usual & Customary Rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance carrier's arbitrary determination of usual and customary rates. Our fees are based on the treatment selected, the time needed to provide you with the necessary dental care and the overhead involved in our practice.

Cancellation Policy

Please help us serve you better by keeping your scheduled appointments or providing a 24-hour notice of cancellation.

Financial

Any expense incurred for returned checks, legal fees and collection agency fees will become your rsponsibility and will be added to your account balance. The fee for a returned check is $10.

We are here to serve your dental needs and to provide you with a pleasant experience. We encourage you to discuss any financial concerns that you may have so that we may assist you in the effective management of your account.

I have read and understand and agree to the office and financial policies described above

PATIENT/GUARDIAN SIGNATURE DATE

COMPLYRIGHT

Healthcare

HIPAA Notice of Privacy Practices

HIPAA Notice of Privacy Practices Tips — The Right Way!

Fast Facts

Purpose

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires health care providers and other covered entities to develop and distribute a notice of privacy practices outlining individuals' rights with respect to their protected health information (PHI) and how it may be used and disclosed by covered entities. Use the HIPAA Notice of Privacy Practices to meet your HIPAA obligations.

Relevant Law

The HIPAA Privacy Rule creates national standards to protect individuals' health information by accomplishing these general goals:

- Gives individuals more control over their health information.
- Sets boundaries on the use and release of health records.
- Establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- Holds violators accountable, with civil and criminal penalties that can be imposed if they violate individuals' privacy rights.
- Enables individuals to make informed choices regarding the use and dissemination of personal health information when seeking care and reimbursement for care.
- Enables individuals to find out how their information may be used, and about certain disclosures of their information that have been made.
- Limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- Gives individuals the right to examine and obtain a copy of their own health records and request corrections.

To comply with the HIPAA Privacy Rule, covered entities generally must:

- Notify individuals about their privacy rights and how their information can be used.
- Adopt and implement privacy procedures for their own practice, hospital, or plan.
- Train their employees so that they understand the privacy procedures.
- Designate an individual to be responsible for seeing that the privacy procedures are adopted and followed.
- Secure individual records containing individually identifiable health information so that they are not readily available to those who do not need them.

Penalties

HIPAA imposes civil and criminal penalties for failing to comply with the Privacy Rule. Penalties begin at $100 per violation, up to a maximum of $50,000, with a calendar year cap of $1.5 million. Criminal penalties apply for a deliberate offense, as in intent to sell protected health information, ranging from $50,000 and one year in prison, up to $250,000 and ten years. HIPAA also makes employers liable for violations of their business associates if the employer is aware of the wrongdoing.

Tips continued on the back

ATTORNEY APPROVED

HIPAA Notice of Privacy Practices Tips — The Right Way!

Fast Facts *(continued)*

Required Content of the Notice of Privacy Practices

Covered entities are required to provide a notice in plain language that includes:

- The following language prominently: "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."
- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must also include an effective date. You are required to promptly revise and distribute your notice whenever you make material changes to any of your privacy practices.

Providing the Notice

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- Health plans must also:
  - Provide the notice to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals of the availability of and how to obtain the notice at least once every three years.
- Health care providers must also:
  - Provide the notice to the individual no later than the first date of service and, except in an emergency treatment situation, make a good-faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the health care provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service to an individual is provided over the Internet, through e-mail, or otherwise electronically, the health care provider must send an electronic notice automatically in response to the individual's first request for service. The health care provider must make a good-faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, health care providers are not required to make a good-faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the health care provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

Do's & Don'ts

DO document compliance with HIPAA notice requirements by keeping copies of the Notice of Privacy Practices you provide to your patients and any written acknowledgments.

Don't forget to check state laws. Some state laws are more stringent that the HIPAA Privacy Rule with respect to the use and disclosure of PHI.

DO treat all patient information as if you were the patient. Don't be careless or negligent with PHI in any form, whether spoken, written or electronically stored.

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____ Date: ___/___/___