Thank you for choosing Chandler Bright Family Dentistry

PATIENT INFORMATION

Name:_____
(First) (Middle Initial) (Last)

Date of Birth:_____/_____/_____

Male Female

Single Minor Married Widowed

Separated Divorced Partnered

Address:_____

City:_____State:_____ Zip Code:_____

Social Security Number:_____-_____-_____

Email Address:_____

Employer/School:_____

Occupation:_____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home: (_____)_____-_____

Mobile: (_____)_____-_____

Work: (_____)_____-_____Ext:_____

Best time and place to be reached:_____

Spouse's Name:_____

Spouse's Phone: (_____)_____-_____

IN CASE OF EMERGENCY CONTACT

(Please specify someone who does NOT live in your household.)

Name:_____

Relationship:_____

Phone #: (_____)_____-_____

INSURANCE INFORMATION

Ins Company:_____
Member/Policy ID # (Can be the subscribers SSN):

_____
Subscriber/Policy Holder Name:

_____
(First) (Middle Initial) (Last)

D.O.B.:_____/_____/_____Employer:_____

***Is the PATIENT covered by secondary insurance*?** YES NO
(if yes please fill out the section below for the secondary insurance.)

Ins Company:_____
Member/Policy ID # (Can be the subscribers SSN):

_____
Subscriber/Policy Holder Name:

_____
(First) (Middle Initial) (Last)

D.O.B.:_____/_____/_____Employer:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to the doctors at Chandler Bright Family Dentistry all insurance benefits, if any, otherwise payable to me 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 submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies)and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____

(PRINTED Name of Patient, Parent, Guardian or Personal Representative)

Relationship to patient:_____

X_____

(Signature of Patient, Parent, Guardian or Personal Representative)

Date:_____/_____/_____

DENTAL HISTORY

Reason for today's visit:_____ How often do you floss:_____

Date of last dental visit:_____ How often do you brush:_____

HEALTH HISTORY

Primary Care Physician's Name:_____Cardiologist (If applicable) _____

Primary Care Physician's Phone:_____Cardiologist's Phone:_____

Please *CIRCLE* "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease (COPD)	Yes	No
Alcoholism	Yes	No	Fainting or dizziness	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Glaucoma	Yes	No	Seizure	Yes	No
Arthritis, Rheumatism	Yes	No	Headaches	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Heart Attack, Year _____	Yes	No	Shortness of Breath	Yes	No
Artificial Knee Joints, Side _____	Yes	No	Heart Disease, Name _____	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis, Type _____	Yes	No	Smoking	Yes	No
Bleeding abnormally, with			Herpes (Cold Sores)	Yes	No	Special Diet	Yes	No
extractions or surgery	Yes	No	High Blood Pressure	Yes	No	"Fen-Phen" Diet	Yes	No
Blood Disease, Name _____	Yes	No	Jaundice	Yes	No	Stent	Yes	No
Blood Thinners, Name _____	Yes	No	Jaw Pain	Yes	No	Stroke, Year _____	Yes	No
Cancer, Type _____	Yes	No	Kidney Disease	Yes	No	Swollen Feet or Ankles	Yes	No
CBD	Yes	No	Liver Disease	Yes	No	Swollen Neck Glands	Yes	No
Chemical Dependency/Addiction	Yes	No	Low Blood Pressure	Yes	No	Thyroid Problems, Hypo or Hyper	Yes	No
Chemotherapy	Yes	No	Marijuana, Medical or Recreational	Yes	No	Tonsillitis	Yes	No
Chewing Tobacco	Yes	No	Mitral Valve Prolapse	Yes	No	Total Hip Replacement, Side _____	Yes	No
Circulatory Problems	Yes	No	Nervous Problems	Yes	No	Tuberculosis	Yes	No
Congenital Heart Defects	Yes	No	Osteoporosis	Yes	No	Tumor or growth on head or neck	Yes	No
Cortisone Treatments	Yes	No	IV infusion (Osteoporosis)	Yes	No	Ulcer	Yes	No
Cough, Persistent or bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes, Type _____	Yes	No	Pre-Med prior to dental treatment	Yes	No	Weight Loss, Unexplained	Yes	No
Depression	Yes	No	Psychiatric Condition	Yes	No	Others: _____		
Emphysema	Yes	No	Radiation Treatment	Yes	No			

WOMEN ONLY:

Are you pregnant? Yes No How many weeks?_____ 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:_____

Phone or Crossroads: _____

ALLERGIES

Aspirin

Amoxicillin

Barbiturates (Sleeping Pills)

Codeine

Iodine

Others_____

Latex

Local Anesthetics

Penicillin

Sulfa

Vicodin

Patient or (Guardian) Signature: ***Date:*** ***Dentist's Signature:*** ***Date:***

Chandler Bright Family Dentistry

General Dentistry Informed Consent/Financial Policy

I Consent to the following treatment to be done periodically: Exams, X-Rays, Prophy (Cleaning), Fluoride.
I understand that Dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that no other dentist is responsible for my dental treatment.
I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for the payment of dental service.

Medications
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of the tissues, pain, itching, vomiting, and /or anaphylactic shock.

Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations .e.g., root canals following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Financial Responsibility
As a courtesy to you, we will file and submit all insurance claims on your behalf. We request that you pay your estimate co-payment at the time of service. Please note that estimate insurance benefits are subject to actual payment by your insurance carrier and NOT a guarantee of payment by your insurance plan. You are ultimately responsible for all fees associated with treatment. A finance charge of 18% is applied on accounts past due 60 or more days. For your convenience, we accept Visa, MasterCard, Discover and CareCredit. The adult parent or Guardian who accompanies a minor is responsible for payment at the time of service. Some of your treatment may not be covered by your insurance carrier. We are not party to the contact and there is nothing we can do regarding coverage provided. The cost for such charges will be your responsibility. Major services may require a deposit equal to at least one half of the estimated patient portion at the time appointment is made.

Collections
After repeated attempts to collect a balance due, we may need turn an account over to a collection agency. Should this occur, it is agreed that the patient listed below shall pay finance charges, collection fees (up to 42% of the full balance), attorney fees and other cost that may be incurred to enforce collection of any amount outstanding.

Pre determination
It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. We can predetermine your benefits with your insurance company; however, this delay treatment 4-6 weeks or longer, waiting for the insurance company to respond, which may not be in the best interest of your oral health.

Photography
I authorized Chandler Bright Family Dentistry to take photographs of me to help me better understand my current dental condition & possible treatment options.

Composite (white) fillings
In our office we do composite fillings. Some insurance companies cover composite fillings, some don't. Every insurance plan is different. When the insurance downgrades the filling to amalgam (silver) filling the difference between both is the patient responsibility.

Thank you for choosing our practice to serve your dental needs.

Print name _____

Signature of patient or Guardian _____ Date _____

NOTICE OF PRIVACY PRACTICES

Protecting your confidential health information is important to us.
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.

OUR PROMISE

Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously the Federal law (HIPPA- Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We do not ever want to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

WHY DO YOU HAVE A PRIVACY POLICY?

Very good question!

The Federal government legally enforces the importance of privacy information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone faxes, copy machines, and charts. WE believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which are developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and the in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting health care operations, and as otherwise described in this notice.

How your HEALTH INFORMATYION may be used to provide treatment.

We will use your HEALTH INFORMATION within our office to provide you with dental care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

To Obtain Payment.

We may include your health information with in invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To conduct health care operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options of services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To business associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to preform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the notice each of these categories of uses or disclosures. The listing is below.

AS REQUIRED BY LAW

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interests.

Public Health and National Security

We may be required to disclose to Federal Officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For law enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by state or federal workers' compensation laws.

Judicial and Administrative Proceedings
We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting part first provides written documentation that the privacy of your health information will be protected.

Incidental uses and disclosures
We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activates
We may use or disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.
To Avert a Serious Threat to Health or Safety
We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

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We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To the US Department of Health and Human Services (HHS)
We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research
We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation
We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.
If applicable State law does not permit the disclosure described above, we will comply with the stricter State Law.

Authorization to Use or Disclose Health Information
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT RIGHTS
You have the following rights related to your health information.

Restrictions
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or health care operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a health care item or service for which you have paid us out of pocket in full.

Confidential Communications
You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We Will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.
Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information
You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than 6 years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or e mail a copy to you.
We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice Of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. If we change our privacy practice we will be sure all of our patients receive a copy of the revised notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please Let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Patient Acknowledgment

Printed Patient Name_____
Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of your policy by signing and returning this card. We look forward to seeing you again soon!

Patient or (Guardian) Signature_____Date_____
For additional information about the matters discussed in this notice please contact or Privacy Officer.