JONATHAN CLEMETSON, DDS
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REGISTRATION

Patient's Last Name_____ First _____ MI _____

I prefer to be called_____ Birth Date _____ / _____ / _____ Age _____ Sex M / F

Social Security # _____ / _____ / _____ Driver's License # _____ State Issued _____

Home Address _____

City _____ State _____ Zip _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell: (_____) _____ - _____

EMERGENCY CONTACT: _____ Phone: _____

E-Mail _____Preferred form of communication: ☐email ☐text ☐phone

By providing my email and text I am giving the office of Dr. Jonathan Clemetson permission to contact me via email, text or by phone for the purposes of meeting my dental needs and any necessary communication. WIRELESS CARRIER: _____

Employer _____ Address _____ Occupation _____

*Who may we thank of referring you to our practice: _____

Spouse's Name _____Spouse's Occupation_____

ACCOUNT INFORMATION

Person Responsible for Account (If different than patient):

Last Name _____ First _____ MI _____

Relationship to Patient _____ Birth Date _____ / _____ / _____ Age _____ Sex M / F

Social Security # _____ / _____ / _____ Driver's License # _____ State Issued _____

Home Address _____ City_____ State _____ Zip_____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____ Cell: (_____) _____ - _____

E-Mail _____Preferred form of communication: ☐email ☐text ☐phone

Employer _____ Occupation _____

Employer's Address _____

DENTAL INSURANCE INFORMATION

Insurance Carrier _____Customer Service #_____

Claims Mailing Address _____

City_____State_____Zip_____

Any additional Insurance coverage:

Relationship to patient _____DOB: _____ ID #_____

Employer _____ Group #_____

Insurance Carrier_____ Customer Service #_____

Claims Mailing Address_____

City_____State_____Zip_____

HEALTH HISTORY

Physicians' Name _____Phone #_____

Physicians Address _____City_____Zip_____

MEDICAL

1. Are you in good health? _____ ☐ YES ☐ NO
   ASA _____
2. Has there been any change in your general health within the past year? _____☐ YES ☐ NO
3. Date of last physical examination? _____
4. Are you now under the care of a physician?_____ ☐ YES ☐ NO
   If so what condition? _____
5. Have you ever had any serious illness, operation, or hospitalization? _____☐ YES ☐ NO
   _____
6. Are you taking any drugs or medication? _____☐ YES ☐ NO

7. List type amount and frequency if so_____

   _____
8. Are you using any recreational drugs? _____☐YES ☐ NO
9. Are you taking any over the counter drugs?_____ _☐ YES ☐ NO
10. Are you sensitive or allergic to any medication? _____☐ YES ☐ NO

☐ Penicillin ☐ Sulfa ☐ Codeine/other Narcotic ☐ Aspirin ☐ Barbiturates ☐ Iodine ☐ other

_____

11. Do you have or have you had any of the following: (Circle known conditions) Other_____

Aids or HIV	Epilepsy	High Cholesterol	Sickle Cell Anemia
Alcohol Abuse	Excessive Bleeding	Kidney Disease	Sinus Trouble
Anemia	Fainting Spells	Liver Disease	Stomach Ulcers
Artificial Joints	Fever Blisters	Mental Disorders	Stroke

Asthma	Glaucoma	Nervous Disorders	Thyroid Problems
Blood Diseases _____	Head Injuries	Radiation Treatment	Tuberculosis
Cancer	Heart Ailments	Respiratory Disease	Tumors/Growths
Chemotherapy	Heart Murmur	Rheumatic Fever	Venereal Disease
Diabetes	Hepatitis	Seasonal Allergies	High Cholesterol
Drug Abuse	Herpes	Seizures	Tobacco Use
Latex Allergy	High Blood Pressure	OTHER	**None of the Above**

If you circled any of the above conditions or added to the "Other" category, please give a brief explanation:

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12. Do you use tobacco now or in the past?_____ ☐ YES ☐ NO

13. Do you wear a cardiac pacemaker?_____☐ YES ☐ NO

14. Have you had Heart surgery? _____ ☐ YES ☐NO

15. Women only: Are you pregnant? YES / NO If yes, how many months? _____ Nursing: YES / NO

b. Are you taking any bisphosphonates? If so, which one? _____ How Long?_____

DENTAL

1. Previous Dentist_____City_____State_____Zip_____
2. Was your pattern of visits ☐regular ☐infrequent ☐sporadic Date of Last Dental Visit_____
3. Have you been having any specific problems?_____ ☐ YES ☐ NO
   Explain_____
4. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment?
   _____☐ YES ☐ NO
5. Does dental treatment make you nervous? _____☐ YES ☐ NO
6. Do you have or have not had any of the following: (Please circle known conditions)

Bad Breath Loosening of teeth Bleeding gums Cold sores Clench your teeth

Sensitive Teeth at . . . . . ☐ Night ☐ Day ☐ Sweet ☐ Temperature

Grind your teeth at. . . . . ☐ Night ☐ Day ☐ Hurt ☐ Lock Jaw ☐ Pop

7. Have you ever had any serious trouble associated with any previous dental treatment or a bad dental experience?

   ☐ YES ☐ NO If yes, please describe: _____

   _____

8. Have you ever had any of the following: ☐ Injury ☐ Oral Surgery ☐ Orthodontics ☐ Periodontics

NEW PATIENT QUESTIONAIRE

Please tell us what type of oral hygiene products you use at home:
Electric Toothbrush: _____
Toothpaste: _____
Floss: _____
Mouth Rinse: _____
Other Home Care Products: _____

Please check all the procedures below that you are interested in?
☐ Check up, Cleaning, X-Rays ☐Second Opinion ☐ Dentures or Partials ☐ Cosmetic Consultation
☐ Teeth Whitening ☐ Porcelain Veneers ☐ Crowns ☐ Tooth Colored Fillings ☐ Dental Implants
☐ Full Mouth Reconstruction/Rehabilitation ☐ Sedation Dentistry ☐ Night Guard
☐ Other
_____

How much do you know about these procedures you are interested in?
☐ I've just begun researching the procedure
☐ I've been researching for the last few months
☐ I know someone who has had the procedure already
☐ I am ready to begin treatment

How soon are you planning to begin treatment?
☐ I am ready to begin
☐ Within 1-3 months
☐ Within 3-6 months
☐ After 6 months

Would you like information about interest free financing? ☐ Yes ☐ No

Briefly explain your current dental situation and what you would like to improve.

_____

_____

Is there anything about your smile or appearance of your teeth you have ever wanted to change/enhance/improve?_____

_____

What are you most concerned about?

_____

_____

OFFICE POLICIES

It is your responsibility to keep all appointments. If you cannot keep your scheduled appointment time, in consideration of other patients in need of treatment, we kindly ask that you give the office a 24 hour advance notice, so that we may offer your reserved time to another patient who is in need of our care. **Missed appointments or appointments cancelled without a 24 hour advance notice are subject to a $119.00 charge.** Initial_____

Payments are due at the time of visit. This includes the patient's estimated portion and deductible amounts. For your convenience, we accept Cash, Check, Visa, and MasterCard. Return checks: Any bad check can and will be turned over to the justice of the peace if the account is not reconciled within 20 days. You will also be responsible for a returned check fee in the amount of $35.

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

Undersigned hereby authorizes Dr. Jonathan Clemetson to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Clemetson to make a thorough diagnosis of patient's dental needs. I also authorize Dr. Clemetson to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Clemetson choose and employ

such assistance as he/she deems fit. I also authorize release of any information concerning my (or my child's) health care, medical history, advice and treatment to another dentist of if applicable, an insurance company. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

CONSENT TO DENTAL PHOTOGRAPHY AND STUDY MODELS

In connection with dental services which I am receiving from Jonathan Clemetson, DDS; I agree and consent to allow the photographs taken and any study models made before, during and after completion of my dental treatments to be used for dental records, research, education, patient counseling, or other purposes.

_____ _____

Patient/Guardian Signature Date Witness Signature Date

INSURANCE POLICIES AND FINANCIAL AGREEMENT

As a courtesy, we will file all primary insurance claims for you for covered services and are happy to help you maximize your insurance benefits. We will need a copy of your current insurance card, and you are required to pay your estimated patient portion and deductibles at the time of service.

_____I UNDERSTAND THAT DR. CLEMETSON IS *OUT OF NETWORK* WITH *ALL* IN SURANCE COMPANIES.

Verification of insurance does not guarantee payment. Payment is subject to review by the insurance company and is determined upon the actual receipt of the claims by the insurance company. Dr. Clemetson's office will file an initial insurance claim on my behalf at no additional cost. If the insurance carrier has not responded or denies payment within 45 days of the date of the service the entire fee for the service is due and payable by me. Any remaining balance regardless of the amount of the insurance payment is my responsibility, and it is my responsibility to contact my insurance company to dispute any denial, or nonpayment issues.

Authorization to pay benefits to dentist: I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

I, _____, understand that any service performed for my dependant or me by Dr. Clemetson or his/her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Clemetson's office responsibility to collect from my insurance company. I, the insured/dependant, have read the above and understand the policies regarding office financial and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services provided.

_____ _____

Patient/Guardian Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIVES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how you health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An Example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in witting and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonably requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information to provide you with notice of our legal duties and privacy practice with respect to protect health information. This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, retaliate against you for filling a complaint.

For Information about HIPAA or to file a Complaint: The U.S. Department of Health & Human Services Office of Civil Rights – 200 Independence Avenue, S.W. Washington, D.C. 20201 – (202)619-0257 – Toll Free : 1-877-696-6775

Patient Consent Form Regarding Notice of Privacy Practices (DENTAL) *You May Refuse to Sign This Acknowledgement*

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. ***I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.***

Patient Name_____**Auth. Signature** _____ **Date**_____