Patient Name:_____

Date of Birth:_____ Social Security #_____ Drivers Lic #:_____

Phone (Home):_____ (Cell):_____ (work):_____

Address:_____ Email: _____
Street City State Zip code

In an emergency who should be notified? (Name/Phone#)_____

Pharmacy, Location & Phone Number:_____

Cardiologist Name, Location, Phone Number: _____

Physician Name, Location, Phone Number: _____

**Please mark any that apply:**

| | | | |
|---|---|---|---|
| ☐ *Pre Medicate | ☐ Blood Thinner | ☐ Bone Density Med | ☐ Heart Disease / Stroke |
| ☐ Artificial Joints | ☐ Pacemaker/Defib | ☐ Diabetes | ☐ Excessive Bleeding |
| ☐ Arthritis | ☐ Cancer | ☐ Mitro Valve / Murmur | ☐ Anemia / Blood Disease |
| ☐ Glaucoma | ☐ Epilepsy | ☐ Mental/Nervous Disorder | ☐ Asthma / Respiratory |
| ☐ Alcohol use | ☐ AIDS / HIV | ☐ High Blood Pressure | ☐ Growths (in or around mouth) |
| ☐ Tobacco Use | ☐ Head Injuries | ☐ Tuberculosis | ☐ Hard Candy / Cough Drops |
| ☐ Dizziness/Fainting | ☐ Ulcer / Stomach | ☐ Tumors / Growths | ☐ Radiation Treatment |
| ☐ Hepatitis | ☐ Sugary Drinks | ☐ Sinus Problems | ☐ Kidney / Liver Disease |
| ☐ Legally Blind | ☐ Hearing Loss | ☐ Pregnancy Due Date: | ☐ Trouble getting numb |
| ☐ Clench / Grind teeth | ☐ Dry Mouth | ☐ Gum recession | ☐ Sensitive hot / Cold / Sweets |

☐ Complications from past dental work

**Please explain any marked answers:** _____

_____

Please List **ANY ALLERGIES** (Medical, Metals, Food, Etc.):_____

_____

Are you taking a **BLOOD THINNER?** (Coumadin, Plavix, Aspirin) Please list:_____

Are you taking or have you ever taken **BONE DENSITY** meds? (Fasomax, Boniva, Actonel, Reclast, Evista) Please List: ____

_____

Please list **ANY** and **ALL medications** you are currently: (We can make a copy of your list.)_____

_____

_____

Please List **ANY SURGERIES** you have had (Dental and Non-Dental): _____

_____

☐ By checking this box, I acknowledge that I have reviewed **ALL** questions/alerts on this page and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any further changes.

_____ _____

Signature of Patient / Parent / or Guardian Date

## Shakamak Family Dentistry

## HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on 4/14/03. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available at www.hhs.gov.

What this is about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information in which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the offices and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning PHI. However, we are not obligated to alter internal policies to conform to your request.

**I give permission to have any and all of my PHI to be released to...**

**Which also includes allowing them to be present while treatment is performed.**
**(Spouse / Mother / Father / Children / Etc.)**

X _____ X _____ X _____

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

**Please Initial and date (1) per Year**

| | | | |
|---|---|---|---|
| _____ Initial | _____ Date | _____ Initial | _____ Date |
| _____ Initial | _____ Date | _____ Initial | _____ Date |

# Patient Financial Responsibility Statement

We are committed to giving each patient the best dental care possible.

**This document must be read and signed by each patient** and will remain in effect for all services rendered during your time as a patient of Shakamak Family Dentistry.

**Insurance Claims:**
Your insurance policy is a contract between you and your insurance company. At the time of your first visit we will contact your insurance company for verification of coverage, co-pay and deductibles. **Payment will be collected at time of service.** We will file for our services with your primary insurance company. Secondary insurance will be filed if adequate information is provided at the time of service.

***It is YOUR responsibility to let us know of any changes with your dental insurance.***

**YOU** are responsible for any percentages that your insurance does not cover (within the contract of your insurance policy).

**Method of Payment:**
For your convenience, Shakamak Family Dentistry, accepts **Cash, Check, Visa, MC, Discover and Care Credit.** Credit/Debit card payments may be made in the office, over the phone or online.

**Accounts Past Due:**
ALL PAST-DUE BALANCES IN COLLECTION MUST BE PAID PRIOR TO BEING SEEN.
Should any bills go unpaid, a collection agency or attorney will be contacted to help collect your balance. You will be responsible for any collection agency/attorney fees. A 40% collection fee will be added to the balance owed.

**No Show/Cancellation Policy:**
If you need to cancel or reschedule your appointment please give at least 24 hours prior to your appointment. **1st** missed appointment, you will be notified & reminded of policy agreement by letter. **2nd** missed appointment you may be subject to a $30 no show fee. **3rd** missed appointment is subject to DISMISSAL.

**Minor/Dependent Patients:**
The adult accompanying a minor/dependent, or the parent(s) or guardian(s), of the minor or dependent is responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless payment is collected at the time services are rendered. Children under the age of 18 will require the signature of a responsible adult party on the patient registration form.

**Notice of Privacy Practice (HIPAA):** I hereby acknowledge that a copy of this offices Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

**Non-urgent professional services** may be delayed or terminated with in guidelines of good dental practice for **BAD FAITH** patient or non-compliance with this financial policy.

**I authorize the staff of Shakamak Family Dentistry LLC** to perform services for the patient registered. I also grant permission to you or your assignee, to telephone / leave message for me at home or work to discuss matters related to dental treatment or collection of a balance.

**Your signature below** indicates that you accept and understand this policy. Further, your signature authorizes Shakamak Family Dentistry to release dental information necessary to process your insurance claims (if any). You herein authorize payment of dental benefits to Shakamak Family Dentistry when an assigned claim is filed.

Signature of Patient / Parent / Legal Guardian Date

## RESPONSIBLE PARTY – INSURANCE INFORMATION

Name: _____ Date of Birth: _____

Social Security #: _____ Drivers Lic #: _____

Phone (Home): _____ (Cell): _____

(Work): _____ Employer Name: _____

Email Address: _____

Mailing Address: _____
Street City State Zip Code

**Responsible Party Information (Person Responsible for Co-Pay, Deductible, Account Balance)**

☐ **Check if same as above.**

Name: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Drivers Lic #: _____ Phone (Home): _____

### Dental Insurance Information

***PLEASE GIVE YOUR DENTAL INSURANCE CARD / CARDS TO RECEPTIONIST TO MAKE A COPY.***

☐ **Please mark box, if patient is card holder or responsible party listed above. If not listed, please fill out information below**

**Primary:**

**Name of Ins. Co:** _____ **ID#:** _____ **Group #:** _____

**Employer Name:** _____ **Employer SS#:** _____

**Name of Policy Holder:** _____ **Policy Holder Date of Birth:** _____
First Last

**Patient Relationship to Policy Holder:** Self: _____ Spouse: _____ Child: _____ Other: _____

**Insurance Plan Name:** _____ **Insurance Co Phone#:** _____

**Insurance Plan Address:** _____ COP
Street City State Zip Code

**Secondary:**

**Name of Ins. Co:** _____ **ID#:** _____ **Group #:** _____

**Employer Name:** _____ **Employer SS#:** _____

**Name of Policy Holder:** _____ **Policy Holder Date of Birth:** _____
First Last

**Patient Relationship to Policy Holder:** Self: _____ Spouse: _____ Child: _____ Other: _____

**Insurance Plan Name:** _____ **Insurance Co Phone#:** _____

**Insurance Plan Address:** _____
Street City State Zip Code

COP