Family Dental

PATIENT REGISTRATION AND MEDICAL HISTORY (please print)

PATIENT LAST NAME/FIRST NAME/INITIAL/PREFERRED NAME	DATE OF TODAY
STREET ADDRESS/ CITY/STATE/ZIP	
HOME PHONE	ALTERNATE PHONE
EMAIL ADDRESS	SEX ☐M ☐F
AGE/DATE OF BIRTH	☐SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED
EMPLOYED BY	OCCUPATION
EMPLOYER ADDRESS	WORK PHONE
SPOUSE/PARENT NAME	SPOUSE/PARENT BIRTHDATE
EMPLOYED BY	OCCUPATION
EMPLOYER ADDRESS	WORK PHONE
WHO IS RESPONSIBLE FOR THIS ACCOUNT?	RELATIONSHIP TO PATIENT
SOCIAL SECURITY NUMBER	SPOUSE/PARENT SOCIAL SECURITY NUMBER
NAME OF DENTAL INSURANCE COMPANY	GROUP NUMBER
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED AND PHONE NUMBER?	WHOM MAY WE THANK FOR REFERRING YOU?

MEDICAL HISTORY

PHYSICIAN'S NAME	DATE OF LAST PHYSICAL

HAVE YOU HAD ANY OF THE FOLLOWING (CHECK BOXES THAT APPLY):

☐HEART PROBLEMS	☐EPILEPSY	☐SPECIAL DIET	☐HIGH BLOOD PRESSURE	☐ARTHRITIS
☐HEADACHES	☐SWOLLEN NECK GLANDS	☐HEPATITIS, JAUNDICE OR LIVER DISEASE	☐LOW BLOOD PRESSURE	☐ HEMOPHILIA
☐RHEUMATIC FEVER	☐CIRCULATORY PROBLEMS	☐CANCER	☐SINUS PROBLEMS	☐DIABETES
☐NERVOUS PROBLEMS	☐PSYCHIATRIC CARE	☐HIV/AIDS OR OTHER IMMUNOSUPPRESSIVE DISORDERS	☐RADIATION TREATMENT	☐BACK PROBLEMS
☐CHRONIC DIARRHEA	☐ THYROID DISEASE	☐ARTIFICIAL HEART VALVES OR JOINTS	☐ALLERGIES TO ANESTHETICS	☐BLOOD DISEASE
☐STROKE	☐RECENT WEIGHT LOSS	☐ALLERGIES TO MEDICINE OR DRUGS	☐CHEMICAL DEPENDENCY	☐ULCER
☐RESPIRATORY DISEASE	☐GENERAL ALLERGIES	☐VENEREAL DISEASE		

DO YOU HAVE ANY DRUG ALLERGIES OR HAVE YOU EVER HAD AN ADVERSE REACTION TO ANY MEDICATION? IF SO, PLEASE DESCRIBE.

HAVE YOU EVER USED A BISPHOSPHONATE MEDICATION? COMMON BRAND NAMES ARE FOSAMAX, ACTONEL, ATELVIA, DIDRONEL, BONIVA. ☐YES ☐NO

HAVE YOU EVER RESPONDED ADVERSELY TO MEDICAL OR DENTAL TREATMENT? ☐NO ☐YES, PLEASE DESCRIBE.

ARE YOU TAKING ANY MEDICATION AT THIS TIME? ☐NO ☐YES, PLEASE DESCRIBE.

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN"? THESE INCLUDE COMBINATIONS OF IONIMIN, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE). ☐NO ☐YES, PLEASE DESCRIBE.

ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐NO ☐YES, FOR WHAT CONDITIONS.

ARE YOU NURSING? ☐YES ☐NO

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? ☐NO ☐YES, PLEASE DESCRIBE.

THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND IS ONLY FOR USE IN MY TREATMENT, BILLING AND PROCESSING OF INSURANCE FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE	DATE

CK Family Dental

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

SECTION A: THE PATIENT	
NAME	ADDRESS
TELEPHONE	EMAIL
PATIENT NUMBER	SOCIAL SECURITY NUMBER

SECTION B: ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE.

I, _____, ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FROM THE ABOVE NAMED PRACTICE.

SIGNATURE	DATE

IF A PERSONAL REPRESENTATIVE SIGNS THIS AUTHORIZATION ON BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME

RELATIONSHIP TO INDIVIDUAL

SECTION C: GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT

DESCRIBE YOUR GOOD FAITH EFFORT TO OBTAIN THE INDIVIDUAL'S SIGNATURE ON THIS FORM:

DESCRIBE THE REASON WHY THE INDIVIDUAL WOULD NOT SIGN THIS FORM:

SIGNATURE

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT.

SIGNATURE	DATE
PRINT NAME	TITLE

CK Family Dental

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE WITH _____

AND ASSIGN DIRECTLY TO DR. _____ ALL BENEFITS. IF ANY, OTHERWISE PAYABLE TO BE FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

SIGNATURE	DATE

MINOR/CHILD CONSENT

I, BEING THE PARENT OR GUARDIAN OF _____

DO HEREBY REQUEST AND AUTHORIZE THE DENTAL STAFF TO PERFORM NECESSARY DENTAL SERVICES FOR MY CHILD, INCLUDING BUT NOT LIMITED TO X-RAYS, AND ADMINISTRATION OF ANESTHETICS WHICH ARE DEEMED ADVISABLE BY THE DOCTOR, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED.

SIGNATURE OF INSURED/GUARDIAN	DATE

FINANCIAL AGREEMENT

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE. I AGREE THAT PARENTS/GUARDIANS ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR/CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE.

SIGNATURE OF INSURED/GUARDIAN	DATE

MEDICAL HISTORY UPDATE

HAS THERE BEEN ANY CHANGE IN YOUR HEALTH SINCE YOUR LAST DENTAL APPOINTMENT? ☐YES, FOR WHAT CONDITIONS. ☐NO

ARE YOU TAKING ANY NEW MEDICATIONS? ☐YES, PLEASE DESCRIBE. ☐NO

SIGNATURE OF PATIENT	DATE
SIGNATURE OF DENTIST	DATE

MEDICAL HISTORY UPDATE

HAS THERE BEEN ANY CHANGE IN YOUR HEALTH SINCE YOUR LAST DENTAL APPOINTMENT? ☐YES, FOR WHAT CONDITIONS. ☐NO

ARE YOU TAKING ANY NEW MEDICATIONS? ☐YES, PLEASE DESCRIBE. ☐NO

SIGNATURE OF PATIENT	DATE
SIGNATURE OF DENTIST	DATE

CK FAMILY DENTAL

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer
Telephone: (251)-675-4423
Fax:
Email: mydentist@smilesaraland.com
Address: 315-C Highway 43 N.; Saraland, AL 36571

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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. We reserve the right to make any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and

2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

CK Family Dental

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

You agree, in order for us to service your account or to collect monies you my owe, CK FAMILY DENTAL, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that CK FAMILY DENTAL, its employee and/or agents may contact me/us as described above.

_____

Responsible party signature Date

CK Family Dental

MEDICAL INFORMATION RELEASE
HIPAA RELEASE

Name _____ Date of birth _____

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse

☐ Child(ren)

☐ Other

☐ Information is not to be released to anyone.

Signed _____ Date _____

Witness _____ Date _____