

Welcome to The Denture Place

(Please Print)

Name _____ Social Security _____

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Email Address _____

Emergency Contact _____ Phone _____

Responsible Party and/or Policy Holder

Name _____ Relationship to Patient _____

Address, if different _____ City/State _____ Zip _____

Social Security _____ Date of Birth _____ Employer _____

Dental History

Reason for this Visit _____

Denture/Partial Patients: *Estimated Month and Year of Current* _____

ARE YOU TAKING BLOOD THINNERS? IF SO, WHAT? _____

HOW DID YOU HEAR ABOUT US?

Billboard on I-75 South Billboard on Hwy 155 Sign/Drove By Yellow Pages
 Our Website FaceBook Insurance Website Internet/Online

OR, Name of Person Who Referred You _____

PATIENT AGREEMENT

While we understand that emergencies occur, your time, as well as ours, is valuable. Our office policy requires that you give us a **24-Hour Notice of Cancellation**. Please be advised that a broken appointment fee of **\$45** will be charged for the time that was **Reserved** for you.

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties to have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

Signature of Patient/Legal Guardian _____ Date _____

Authorized Party _____ Please Circle: Significant Other Parent Child

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



Payment Policy

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the quality care needed to enjoy a healthy and confident smile.

PAYMENT IN FULL

Full payment is required at the time of service from all patients that do not have insurance coverage.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. We cannot guarantee any **estimated** coverage. Your unpaid deductible and any **estimated** portion of fees not covered by your insurance are due at the time of service. Because the insurance policy is an agreement between you and the insurance company, we ask that patients be directly responsible for any unpaid balance. If for any reason your insurance company has not paid their portion within 60 days from the date the claim is filed, you are responsible for the balance.

PAYMENT OPTIONS

Cash or Check: For Treatment Paid in Full (No Insurance Filed) at the Time Services are Rendered, a 5% Courtesy Adjustment will be offered.

Credit Cards: American Express, Discover, Mastercard, Visa, and CareCredit

Payment Plans: In order to keep our cost down and pass it on to our patients, we do not offer an in-house payment plan. However, we do offer **CareCredit** and would be happy to help you with the application. There are no application fees or down payment and the loan can be interest-free.

PAST DUE BALANCES

A past due balance is any amount owed from a prior visit where insurance is not pending or an insurance payment has not been received within 60 days. Or, the insurance did not pay what was **estimated**. All unpaid balances are subject to a 1.5% monthly service charge. Any past due balance will be required to be paid before incurring any new charges. All future charges will need to be paid at the time services are rendered. Severely delinquent accounts will be assigned to a collection agency.

RETURNED CHECKS

Checks returned for insufficient funds will be subject to a \$30.00 service fee.

RED FLAG RULE

The Red Flag Rule was created by the Federal Trade Commission, along with other government agencies, such as the National Credit Union Administration, to help prevent identity theft. The rule was passed in January 2008. In order to comply with this rule, our office will be requiring the following information in order to be treated in our facility.

1. All new patients (or current patient without one on file) will be required to present a valid photo identification card issued by a local state or federal government agency, and we shall copy said identification to keep in our files.
2. For new patients with insurance, information will be verified with their insurance company prior to being seen.

If a Patient Refuses to Present Identification:

- a. In an emergency situation, we shall refer the patient to the nearest hospital for care;
- b. In a non-emergency situation, we shall reschedule the appointment for a later date in which the patient will be required to bring the necessary identification.

You have the right to a paper copy of this notice. You may ask us to give you a paper copy of this Notice at any time. To obtain a paper copy, please ask our patient care coordinator at the front desk.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse "protected health information" (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have legal obligations to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect on _____, and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time, provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices, we will provide you with a copy of the revised Notice of Privacy Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website, mailing you a copy, or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatment: We may use or disclose your PHI to personnel in our office, as well as to physicians and other healthcare professionals within or outside our office, who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and/or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities. For example, we may disclose PHI to medical students who are performing work with our office, or call your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or letters. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors, for the purpose of performing specified functions on our behalf and/or providing us with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our

business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends, and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort, or another person responsible for or involved in your care. If you are present, prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death, or in emergency circumstances, if deemed appropriate based upon our professional judgment, we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to obtain prescriptions, medical supplies, x-rays, or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we may disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities. Under certain circumstances, we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody.

Fundraising: We may contact you in relation to fundraising activities, however you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by Law: We may use or disclose your PHI when we are required to do so by law. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations, and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a sale of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization: In addition to our use of PHI as described in this Notice of Privacy Practices, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. If the Practice maintains any psychotherapy notes, they will not be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA), our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically, with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary, you must make a request in writing and provide us a reasonable amount of time to respond, generally thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost,

electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We will notify you of a breach of your unsecured PHI, as required by HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment, healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency circumstances.

Electronic, Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format, or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request, in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail, you are entitled to receive a copy in written form.

QUESTIONS AND COMPLAINTS

If you have any concerns that we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI, or to have us communicate with you by alternative means or at alternative locations, you may contact us using the information listed below.

In addition, you may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the contact information for filing a complaint upon request. We support your right to the privacy of your PHI. 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.

If you would like additional information regarding our privacy practices, or if you have questions or concerns, please contact us as indicated below.

Contact Officer:

Address:

Telephone:

Fax:

Email: