General Patient Information

Patients Full Name: ______________________________

Sex: __ M __ F Date of Birth: __________ Age: ______ SSN: __________

Address: ____________________ City: __________ State: ______ Zip: __________

Home Phone: __________ Cell: ____________________ Work: ____________________

Patient Occupation: ____________________ Employer: ____________________

Email Address: ____________________ Referring Doctor: ____________________

Responsible Party (Financial)

Name: ____________________ Sex: M F Date of Birth: __________

Address: ____________________ City: __________ State: ______ Zip: __________

Home Phone: __________ Work: ____________________

Employer: ______________________________

Please list any family members we have seen: ______________________________

Insurance Information:

Primary Dental Insurance: ____________________ Insurance Ph#: __________

Insurance Address: ______________________________

Subscriber's Name: ____________________ Subscribers DOB: __________

ID #: __________ Group #: ____________________

Secondary Dental Insurance: ____________________ Insurance Ph#: __________

Insurance Address: ______________________________

Subscriber's Name: ____________________ Subscribers DOB: __________

ID #: __________ Group #: ____________________

Health History

For the following questions, check yes or no, whichever applies. Your answers are for our records only and will remain confidential.

ALLERGIES & MEDICATIONS (*Check all that apply)*

Are you allergic to or have you had a reaction to:

- ☐ Local Anesthetics
- ☐ Penicillin or Antibiotics
- ☐ Sulfa Drugs
- ☐ Barbiturates or Sleeping Pills
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine/Narcotics
- ☐ Latex or Rubber Products
- ☐ Other: (List Below)

Please list all known allergies: ____

____

Please list any medicine(s) you are taking including diet pills, non-prescription, vitamins, homeopathic or natural remedies: ____

____

What is the reason for today's visit? ____

Are you under the care of a physician?	Yes	No
Have you had any serious illness, operation or hospitalization in last 5 years?	Yes	No
Have you had an artificial joint replacement (knee, hip, shoulder, etc.)?	Yes	No
Are you taking/have you ever taken bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers?	Yes	No
Do you have unhealed/recurrent injuries or inflamed areas, growths, or sore spots in or around your mouth?	Yes	No
Are you taking blood thinners (Coumadin, Aspirin, Vitamin E, Gingko)?	Yes	No
Have you ever taken tranquilizers, sleeping pills, antidepressants, or narcotics?	Yes	No
IF yes, please list:		
Have you had any serious trouble associated with previous dental treatment?	Yes	No
Are you wearing removable dental appliances?	Yes	No
Are you wearing contact lenses?	Yes	No

Do you have any of the following diseases or problems?

- ☐ Damaged Heart Valves, Artificial Valves, or Heart Murmur
- ☐ Rheumatic Heart Disease
- ☐ Angina
- ☐ High/Low Blood Pressure
- ☐ Stroke
- ☐ Arteriosclerosis or Any Other
- ☐ Heart Condition
- ☐ Chest Pain Upon Exertion
- ☐ Shortness of Breath
- ☐ Swelling of Ankles
- ☐ Stomach Ulcer or Hyperacidity
- ☐ Alcohol/Chemical Dependent
- ☐ Smoke/Chew Tobacco- How much? __________
- ☐ Sinus Trouble
- ☐ Asthma or Hay Fever
- ☐ Fainting Spells/Seizures
- ☐ Diabetes
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Thyroid Problems
- ☐ Respiratory Problems
- ☐ Emphysema/Bronchitis
- ☐ Arthritis/Painful Swollen Joints
- ☐ Osteoporosis
- ☐ Kidney Troubles
- ☐ Persistent Cough
- ☐ Persistent Swollen Neck/Glands
- ☐ Epilepsy/Neurological Disorder
- ☐ Cancer
- ☐ Blood Disorder
- ☐ Treatment for a Tumor/Growth
- ☐ Radiation Therapy to the head, neck or jaw
- ☐ Depressed Immune System
- ☐ Tuberculosis

Health History Continued

Do you have any other conditions or diseases you think the doctor should know about?	Yes	No

If yes, explain: ____

Do you wish to talk to the doctor privately about anything? Yes No

WOMEN Only

☐ Pregnant or Trying to Become Pregnant ☐ Nursing

☐ Problems associated with Menstrual Period ☐ Taking Birth Control

Accident Related Visit:

Date of Injury: Insurance Company Handling This Claim:

Claim Number: Insurance Address:

**I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.*

Date: ____________ Patients Signature: ____

FINANCIAL AGREEMENT

INSURANCE AUTHORIZATION ASSIGNMENT:

I hereby authorize any/all doctors associated with Elko Dental Specialists to furnish information to insurance carriers concerning illness/accident or any treatments. I hereby assign all dental/medical payments to the physician(s) dental/medical services rendered to my dependents or myself.

_________ Patient Initials

PATIENT AND INSURANCE ESTIMATES:
Your treatment plan will reflect an estimated portion of payment for both insurance and the patient.
All insurance estimates are based on the insurance information provided and is an estimate only. This is not a guarantee of payment.
I understand that treatment payment estimates are estimates only and that my insurance may not pay total estimated amounts. I understand that I am responsible for any amount not covered or paid by my insurance.

_________ Patient Initials

FINANCIAL RESPONSIBILITY AGREEMENT:
It is the policy of this office to require full payment for your office exam and x-rays (if required) at the time of the exam if you do not carry active dental insurance.
It is the policy of this office to require estimated patient portion paid on the day of service, prior to the procedure.
I understand that even though I may have dental insurance coverage I am responsible for the balance in full within 60 days of any services rendered, whether or not my insurance has paid.

__________ Patient Initials

____
Patient Printed Name

____
Patient Signature Date

____
TX Coordinator Signature

NOTICE OF PRIVACY PRACTICES HIPPA

As required by "HIPPA", 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.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully

Why do we collect your personal information?
We collect personal information from you for a number of reasons, including helping us determine the appropriate products to offer our patients, provide case management services, and provide quality improvement services.

How do we collect your personal information?
We collect your personal information through you.

How do we protect your personal information?
We protect your personal information by:

Treating all your personal information that we collect as confidential

Stating confidentiality policies and practices in our employee manuals as well as disciplinary measures for privacy violations

Restricting access of your personal information to only those employees who need to know in order to provide our services to you

Only discussing your personal information that is necessary for providing quality treatment

Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information

How do we use and disclose your personal information?
We will not disclose your personal information unless we are allowed or required by law to make the disclosure, or if you (the patient) give us permission. Uses and disclosures, other than those listed below, require your authorization. If there are other legal requirements under applicable state laws that further restrict our use or disclosure of your personal information, we will comply with those legal requirements as well. Following are the types of disclosure we may make as allowed or required by law:

Treatment: We may use and disclose your personal information for our treatment activities. Treatment activities include disclosing your personal information to another health care provider to treat you.

Payment: We may use and disclose your personal information for our payment activities, including the payment of services delivered you.

Health Care Operations: We may use and disclose your personal information for our internal operations.

To Your Parents, if You are a Minor: Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of the state, and will make disclosures consistent with such laws.

Your Family and Friends: If you are unable to consent to the disclosure of your personal information, such as in a medical emergency, we may disclose your personal information to a family member or friend to the extent necessary to help with your health care or with payment for your health care. We will only do so if we determine that the disclosure is in your best interest.

Public Health and Safety: We may disclose your personal information if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your personal information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We must disclose your personal information when we are required to do so by law.

Process and Proceedings: We may disclose your personal information in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose limited information to law enforcement officials.

What are your rights regarding our use and disclosure of your personal information?
You have the right to request all of the following:

Access to Your Personal Information: You have the right to review and receive a copy of your personal information.

Amendment: You have the right to request that we change your personal information. Your request must be in writing and it must identify the information that you think is incorrect and explain why the information should be amended. We may decline your request for certain reasons, including if you ask us to change information that we didn't create. If we decline your request to amend your records, we'll provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.

Accounting of Disclosures: You have the right to receive a report of the instances in which we disclosed your personal information for purposes other than treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for a disclosure

made prior to April 14, 2003. We will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your personal information, a description of the personal information we disclosed, the reason for the disclosure, and other applicable information.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your personal information for treatment, payment, and health care operations to persons you identify. We may be unable to agree to your requested restrictions. If we do, we will abide by our agreement (except in an emergency).

Confidential Communication: You have the right to request that we communicate with you in confidence about your personal information by alternative means or to an alternative location. If you advise us that

Disclosures of all or any part of your personal information could endanger you, we will comply with any reasonable request provided you specify an alternative means of communication.

When is this notice effective?

This notice takes effect April 14, 2003 and will remain in effect until Elk Dental Specialists makes changes to our privacy policies.

What if this office privacy policies change?

We reserve the right to change our privacy policy practices and the terms of this notice at any time, provided such changes are permitted by law.

We May also:

Create and distribute de-identified health information by removing all references to individually identifiable information.

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.

For any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing 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 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 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 reasonable 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 receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

WHY DO WE COLLECT YOUR PERSONAL INFORMATION?

We collect personal information from you for a number of reasons, including helping us determine the appropriate products to offer our patients, provide case management services, and provide quality improvement services.

HOW DO WE COLLECT YOUR PERSONAL INFORMATION?

We collect your personal information through you.

HOW DO WE PROCTECT YOUR PERSONAL INFORMATION?

We protect your personal information by:

Treating all your personal information that we collect as confidential

Stating confidentiality policies and practices in our employee manuals as well as disciplinary measures for privacy violations

Restricting access of your personal information to only those employees who need to know in order to provide our services to you

Only discussing your personal information that is necessary for providing quality treatment

Maintaining physical, electronic and procedural safeguards that comply with federal and state regulations to guard your personal information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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.

Notice of Privacy Practices HIPPA

I have received, read, and understand the *Notice of Privacy Practices* of Elko Dental Specialists containing a complete description of the uses and disclosures of my health information. 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 to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Elko Dental Specialists restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Elko Dental Specialists is not required to agree to my requested restrictions, but if Elko Dental Specialists does agree then the practice is bound to abide by such restrictions.

Relationship to Patient

- SELF
- SPOUSE
- PARENT/GUARDIAN

____

Print Name

Patient Signature Date