Patient Information Form

Date:_____ Birth Date:_____

Patient Name:_____ Gender: Male □ Female □

Address:_____City:_____Zip Code:_____

Home Phone #:_____ Cell Phone #:_____

Email Address:_____ Parent or Guardian Name:_____

Social Security Number:_____ □ Minor □ Single □ Married □ Widowed

Do you have Dental Insurance? □ YES □ NO Do you have a Secondary Dental Insurance? □ YES □ NO

Subscriber Name:_____ Subscriber Birth Date:_____

Subscriber Employed By:_____Occupation:_____

Subscriber SSN:_____ Subscriber Insurance Company:_____

Subscriber Insurance ID #:_____

How Did You Find Us???

□ Referred from a patient. Who? _____ □ One of our employees. Who?_____

□ Internet □ Office Sign □ Through the Mail □ Other Source?

Consent

I give this practice my consent to use or disclose my protected health information to carry out my treatment, obtain payment from insurance companies, and for health care operations like quality reviews. I have been informed that I may preview the practice's Notice of Privacy Practices for a more complete description. I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature:_____ Date:_____

Dental History

Last Dental Visit was on: _____

How do you react to Dental work? □ Dread it □ Worry about it □ Don't mind it

YES NO Please check the appropriate box:

□ □ Are you experiencing pain or discomfort in your mouth at this time? If so, where?

Lower Right Lower Left Upper Right Upper Left

□ □ Are there any areas in your mouth that are sensitive to hot/cold/sweet? If so, where?

Lower Right Lower Left Upper Right Upper Left

One on a scale of 1-10 how would you rate your smile? (ten is the best)

1 2 3 4 5 6 7 8 9 10

□ □ Are you aware of any lumps in your mouth?

Are there any other concerns not listed above? _____

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.**

You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of My Family Dental Clawson, on my behalf regarding **(please check all items authorized).**

Name of authorized person(s):_____

Relationship to patient:_____

Authorized to speak with staff about:

Appointments □ Dental Treatment □

Financial □ Insurance □

DO NOT RELEASE INFORMATION TO ANYONE □

Medical History

Are you under the care of a physician?_____ If yes, Condition?_____
Have you ever been hospitalized or had a major operation? □ YES □ NO
Have you ever had a serious head or neck injury? □ YES □ NO
Are you taking any medications, pills, or drugs? □ YES □ NO
If yes, what are they? _____
_____
Do you take, or have you taken, Phen-Fen or Redux? □ YES □ NO
Have you been advised by a physician to pre-medicate with an anti-biotic? □ YES □ NO
Do you use tobacco? □ YES □ NO
Do you use controlled substances? □ YES □ NO

Women: Are you…. □ Pregnant or 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

Do you have, or have had, any of the following?

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

To the best of my knowledge, all the proceeding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the Dentist or Staff at the next appointment.

Patient Signature:_____ Date:_____

PATIENT PAYMENT POLICY

Patients who are covered under an insurance policy are responsible for anything that their insurance does not cover. Insurance estimates are provided as a courtesy. **In the event that your insurance carrier pays less than the estimate, you are responsible for the unpaid balance. Estimates we provide are based on the information that your insurance company has provided to us.** All payments are due at the time of service and all unpaid balances are subject to late charges. Payment for these services can be made by cash, check, and/or credit/debit card. If patients need to make payment arrangements for their portion they must speak to the treatment coordinator prior to the rendering of ANY services.

PAYMENT ARRAGEMENTS

For patient portions exceeding $200, patients may contact Care Credit for up to 12 months of interest free financing. This service must be applied for PRIOR to services. Please ask our front office for any information if you're interested in this type of financing. For patient portions less than $200, an automatic payment may be made using a debit/credit card. This type of arrangement may only be made if discussed and approved first with the treatment coordinator. If approved for automatic payments, a card must be left on file and charged monthly for no longer than 3 months.

RETURNED CHECK POLICY

There will be a $25 charge for all returned checks. Patients are responsible for any bank charges that may be assessed. Payment for the returned check must be made with cash or a debit/credit card.

COLLECTION AGENCY POLICY

Services rendered must be paid within 30 days from the date of service unless financial arrangements are made PRIOR to services. This is regardless of insurance paying their estimated portion. If the account is delinquent for 90 days, a letter will be sent to the patient notifying them of our decision to send the account to collections. The patient will then have 10 days to make a payment in full on the delinquent account or it will be sent to collections immediately. If the account goes to collections the patient is responsible for any fees incurred.

FAILED/SHORT-NOTICE CANCELLATION POLICY

My Family Dental Clawson requires a **24 hour notice** to either cancel or change an appointment. If you are scheduled for a surgical procedure, we require a **48 hour notice**. If proper notice is not given on the first offense, the patient will be provided with a verbal warning. On the second offense, the patient will be charged a non-refundable $100 fee.

I have read, understand, and agree to honor the above policies.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Dental Warranty

Our practice is proud of the dentistry that we provide to you and your family. Our goal is not to just correct any dental problems you may have, but to show you how to prevent dental disease in the future to save you time and unnecessary expense. The long term success of the dental treatment we provide for you depends upon your continuing home care of your teeth and gums, regular professional exams, and cleaning and fluoride treatments. The products recommended by us for you and the frequency of those professional recare visits depends on your individual condition. Those visits may be every 3, 4, or even 6 months apart depending on your oral health. With that in mind we offer the following limited dental warranties:

Composite Fillings

If a composite restoration is the recommended treatment of choice, we will replace or repair it in the event of failure for a period of 2 years following the procedure. If the tooth breaks and requires a crown or onlay during the 2 year period, we will credit the cost of the filling towards the crown or onlay. You must keep the prescribed hygiene recall appointments in order to maintain this warranty; you must also complete all other treatment prescribed by your Dentist in order to maintain this warranty.

Root Canals

Root Canal treatment is about 95% successful. They do occasionally fail. If you lose your tooth within 2 years of the procedure due to failure of the root canal, we will compensate accordingly. You must keep the prescribed hygiene recall appointments in order to maintain this warranty; you must also complete all other treatment prescribed by your Dentist in order to maintain this warranty.

Crowns, Bridges, Inlays, Onlays, and Porcelain Facings

We will warranty these most comprehensive procedures for a full 5 years. We will replace or repair them at no charge during this 5 year period if they break, are lost, or decay with normal use (this does not include accidents that could break normal healthy teeth.) You must keep the prescribed hygiene recall appointments in order to maintain this warranty; you must also complete all other treatment prescribed by your Dentist in order to maintain this warranty.

Dentures and Partial Dentures

We will warranty dentures and partials for a period of 2 years if a tooth chips or breaks, or a flange breaks under normal use. This warranty does not cover accidents such as dropping your dentures. Full upper and lower denture patients must be seen once every 12 months. Patients with some of their own natural teeth must keep the prescribed hygiene recall appointments in order to maintain this warranty; you must also complete all other treatment prescribed by your Dentist in order to maintain this warranty.

I have read and understand the above warranties.

_____ _____

Patient Signature Date

Acknowledgement Form

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Name of Patient (PLEASE PRINT)

Signature of Patient Date

YOU MAY REFUSE TO SIGN THIS ACKNOWLEGEMENT

BELOW THIS LINE FOR OFFICE USE ONLY

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY

_____
_____
_____

SIGNATURE TITLE DATE

NOTICE OF PRIVACY PRACTICES IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT: Our Privacy Contact THIS NOTICE DESCRIBES HOW DENTAL/MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT You will be asked by your dentist to sign a consent/acknowledgement form. By signing that form, your dentist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your PHI (protected health information) to pay your health care bills and to support the operation of the dentist's office. Following are examples of the types of uses and disclosures of your protected health care information that the dentist's office is permitted to make once you have signed our consent/acknowledgement form.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party that has already obtained your permission to have access to your protected health information. **Payment:** Your protected dental information will be used, as-needed, to obtain payment for your dental services. This may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. **Healthcare operations:** We may use or disclose, as-needed, your PHI in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your dentist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed. **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your dental care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. **Emergencies:** We may use or disclose your PHI in an emergency treatment situation. If this happens, your dentist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your dentist or another dentist in the practice attempts to obtain consent, he or she may still use or disclose your PHI to treat you. **Communication barriers:** We may use and disclose your PHI if your dentist or another dentist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the dentist determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

<u>We may use or disclose your PHI in the following situations without your consent or authorization</u>

When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must take disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance. You have the right to inspect and copy your Protected Health Information (PHI) **You have the right to request a restriction of your PHI.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you request. If dentist believes it is in your best interest to permit use and disclosure of your PHI, your protected health information will not be restricted. If your dentist does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact. You may have the right to have your dentist amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of privacy Practices. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR AFTER <u>APRIL 14, 2003.</u>All forms are for educational use only and do not constitute legal advice. All forms are subject to changes in the federal law and applicable state laws. Seek legal advice before use.