Patient Registration

First Name | MI | Last Name

Address

City | State | Zip

Primary Phone | Secondary Phone

Driver's License # | Email

Birthdate | Social Security #

Emergency Contact / Relationship | Phone Number

Preferred Dentist | Preferred Hygienist

Preferred Pharmacy | Pharmacy Number

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Gender:

- ☐ Male
- ☐ Female
- ☐ Unspecified
- ☐ Other _____

Responsible Party (Same as Patient ☐ Yes or ☐ No)

First Name | MI | Last Name

Address

City | State | Zip

Primary Phone | Secondary Phone

Driver's License # | Email

Birthdate | Social Security #

Who can we thank for your visit with us today?

- ☐ Drive/Walk By
- ☐ Insurance Company
- ☐ Another Office _____
- ☐ Patient Referral _____
- ☐ Other _____
- ☐ Online Search
- ☐ Mailer
- ☐ Radio
- ☐ Staff

Primary insurance information

Policy Holder | Relationship to Patient

Insurance Company Name | Insurance Company Address

Insurance Company Phone | City, State, Zip

Employer Name | Employer Phone Number

Patient/Member ID | Group Number

Secondary insurance information

Policy Holder | Relationship to Patient

Insurance Company Name | Insurance Company Address

Insurance Company Phone | City, State, Zip

Employer Name | Employer Phone Number

Patient/Member ID | Group Number

Student Status: ☐ Full Time ☐ Part Time

Are there particular concerns you would like to discuss with the doctor?

- ☐ Toothache / Pain
- ☐ Removal of Wisdom Teeth
- ☐ Bridge / Partial / Denture
- ☐ Gum Bleeding / Pain
- ☐ Chipped or Cracked Tooth / Teeth
- ☐ Invisalign / Braces
- ☐ Implants
- ☐ Sedation Dentistry
- ☐ Other

Additional Information/Comments:

ALLEN DENTAL CENTER

Medical History

Patient Name _____ Date _____

Are you under a physician's care now?
☐ No ☐ Yes _____

Have you ever been hospitalized or had a major operation?
☐ No ☐ Yes _____

Have you ever had a serious head injury?
☐ No ☐ Yes _____

Are you on a special diet?
☐ No ☐ Yes _____

Do you take, or have you taken, Blood Thinners, Phen-Fen or Redux?
☐ No ☐ Yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
☐ No ☐ Yes _____

Do you use tobacco?
☐ No ☐ Yes _____

Do you use a controlled substance?
☐ No ☐ Yes _____

Are you taking any medication?
☐ No ☐ Yes Please list below

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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

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

Are you allergic to any of the following?

☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Acrylic
☐ Metal
☐ Latex
☐ Sulfa Drugs
☐ Other _____

Women, are you?

☐ Pregnant or Trying to Get Pregnant
☐ Nursing
☐ Taking Oral Contraceptives

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 _____ Patient Name _____ Date _____

ALLEN DENTAL CENTER

Notice of privacy practices

Our legal duty

We are required by applicable federal and state low to maintain the privacy of your health information. We are also required to give you

Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14. 2003 and will remain in effect until 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 the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we retain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

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

Uses and disclosures of health information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: we may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: we may use and disclose your health information in connect ion 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 or credentialing activities.

Your authorization in addition to our use of your health information tor treatment, payment, or healthcare operations, you may give us written authorization to use your health information 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. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: we must disclose your health information to you, as described in the Patient Right's section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: we may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures, in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 pick up filled prescriptions, medical supplies, x- rays, or other similar forms of health information.

Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: we may use or disclose your health information when we are required to do so by law.

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

National security: we may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence. and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment reminders: we may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient rights

Access: you have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as
copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you requested copies, we have the right to charge you $0.05 for each page. $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request on alternative format, we will charge a cost- based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure accounting: you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations. and certain other activities for the last 6 years, but not before April 14, 2003. It you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: you have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative communication: you have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory
explanation of how payments will be handled under the alternative means or location you request.

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

Electronic notice: if you receive this Notice on our web site or by electronic main (email), you are entitled to receive this Notice in written form.

Questions and 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 health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health 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.

If you want more information about our privacy practices or have questions or concerns, please contact our office.

Use and Disclosure of Health Information Consent Form

Patient Name

Responsible Party

Relation to Patient

Please read the following statements carefully.

By signing this form, you consent to the use and disclosure of your protected health information, including x-rays, photographs. and videos. to carry out treatment, payment activities, clinical review and training, and healthcare operations by our office.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before signing this Consent. Our Notice provides a description of our treatment. payment practices, clinical review and training, healthcare operations, of the uses and disclosures we may make of your protected healthcare operations, and of other important matters about your protected health information. A copy of this notice is available upon request We encourage you to read it carefully and completely before signing this Consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices. we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of this Consent or Notice of Privacy Practices at any time by contacting our office.

Right to revoke: You will have the right to revoke this Consent at any time by providing written notice of your revocation of this Consent. Your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. We reserve the right to decline to treat you or continue treating you if you revoke this Consent.

By signing this consent form, I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, clinical review and training, and healthcare operations

Signature

Date

ALLEN DENTAL CENTER

Financial Policy

Patient Name

Responsible Party

Relation to Patient

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care.

Our office works with most dental insurances. We are considered **out of network**. Some policies do not allow for out of network coverage. As a courtesy our office accepts assignment of your primary insurance benefits so that you will not be out of pocket for the full amount of service. Our office will estimate your primary insurance benefits for each visit. We can generally estimate your benefits with reasonable accuracy; however, you will be held fully responsible for any amount not paid by insurance regardless of the reason they refuse payment. Insurance often does not pay as much as expected or ma refuse payment for certain procedures based on your policy provisions. Waiting periods and other clauses/exclusions will also affect your coverage. Please note your insurance policy is an agreement between yourself, your employer and the insurance company. Please know that we will do everything possible to see that you receive the full benefits of your primary policy. Your estimated portion is due and payable in full at the time of your visit. We do not accept assignment of benefits for secondary/supplemental insurance coverage and secondary benefits will not be considered when figuring out of pocket expenses for services. If you require financial assistance in planning for your portion of the bill, please make arrangements with our office prior to your scheduled treatment date. If for any reason your insurance company has not paid their portion within 45 days of your date of service, you may be asked to pay the balance in full at that time.

Notice to Delta Dental Patients: As mentioned above, our office is considered an out of network provider. The majority of Delta Polices will only make payment to the policy subscriber (patient) when an out of network dentist is seen. For this reason, our office requires Delta policyholders (our patients) to make payment in full at time of service. As a courtesy, we will file your claims to Delta for reimbursement to you.

Full payment is due at the time of service. We accept cash, checks, and most major credit cards. There will be a $35.00 fee on all returned checks. We reserve the right to charge for appointments canceled or broken without 24 hours advance notice.

As a courtesy our office extends the following discounts to our patients that qualify. For our patients 65 and older we extend a 10% Senior Citizens discount on all services paid in full at time of service. For all patients our office extends a 5% "in full" discount when services exceed $500 in one visit and the total of those services is paid in full at the time of service. Cash discounts will not be extended to patients utilizing our assignment of benefits on their insurance. Only one discount may be applied per person per visit.

In order for our office to properly manage your dental care needs current information is imperative. Please help our office keep your records up to date by informing us of any changes to your account. This would include but not be limited to: name, address, phone numbers, email address, employer, insurance and all medical/health history.

At our discretion. any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection for the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

Signature

Date

ALLEN DENTAL CENTER

Broken Appointment Policy

Reserved appointment time in our dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so may prevent other patients from receiving needed dental care in a timely fashion.

So that our dentists, staff, and patients will not be penalized by those who fail to keep scheduled appointments. failure to keep a scheduled appointment without 24 hours advance notification will result in a $50.00 cancelation fee. That charge, in accordance with the broken appointment policy for all of our patients, is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff. Do not hesitate to ask if you have any questions.

Signature _____ Date _____

ALLEN DENTAL CENTER