

# Welcome

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # \_\_\_\_\_

SS#/SIN \_\_\_\_\_

Date \_\_\_\_\_

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License# \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain) .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux? .....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revati, Cialis or Levitra in the last 24 hours? .....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances? .....	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Latex Rubber .....	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Other (please list) _____		
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Women Only:		
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives? .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>		Yes	No
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>			
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>			
Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face) .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

**X**

Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Welcome

Patient ID # \_\_\_\_\_ Today's Date \_\_\_\_\_

*to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.*

## Your Child

Child's Name \_\_\_\_\_  
Nickname \_\_\_\_\_ Sex \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
SS# / SIN \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Phone \_\_\_\_\_

## Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Email \_\_\_\_\_  
Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
DL# \_\_\_\_\_

## Who is responsible for making appointments?

Name \_\_\_\_\_ Best time to call \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Time \_\_\_\_\_ Day \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

## Mother

Stepmother  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

## Father

Stepfather  Guardian

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_  
Email \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
DL # \_\_\_\_\_

**Marital Status**  Single  Married  Divorced  
 Widowed  Separated

**Marital Status**  Single  Married  Divorced  
 Widowed  Separated

## Primary Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Additional Insurance

Insured's Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Employee # \_\_\_\_\_  
Ins. Co. address \_\_\_\_\_  
City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
Deductible \_\_\_\_\_ Copay \_\_\_\_\_  
Amount already used \_\_\_\_\_  
Max. annual benefit \_\_\_\_\_

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.  Cash  Personal Check  
 Credit Card  Visa  MC  I wish to discuss the office's payment policy.  
 Discover  AMEX

**Dental & Health History**

**CONFIDENTIAL**

Patient ID # \_\_\_\_\_

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? \_\_\_\_\_ How often does your child floss? \_\_\_\_\_

Is your child's water fluoridated?.....  Yes  No Does your child take fluoride supplements?.....  Yes  No

Does your child:

Suck thumb/finger.....  Yes  No Chew hard objects (pencils, etc.).....  Yes  No

Suck/Bite lip.....  Yes  No Grind teeth.....  Yes  No

Bite/Chew nails.....  Yes  No Clench jaws.....  Yes  No

Previous dentist \_\_\_\_\_ Address \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_

Has your child had difficulty with previous dental visits?  Yes  No

Child's physician \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses? \_\_\_\_\_ When? \_\_\_\_\_

Is your child currently taking medications?  Yes  No (if yes, please list)

Has your child ever taken FenPhen/Redux?  Yes  No

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)?  Yes  No (if yes please describe) \_\_\_\_\_

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?  Yes  No

Has your child ever had any of the following:

Asthma..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach, liver or kidney problems..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever..... <input type="checkbox"/> Yes <input type="checkbox"/> No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Defect..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur..... <input type="checkbox"/> Yes <input type="checkbox"/> No
Acid Reflux..... <input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions/Epilepsy..... <input type="checkbox"/> Yes <input type="checkbox"/> No
	Osteoporosis..... <input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain any medical problem that your child has: \_\_\_\_\_

**Authorization & Release**

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_  
Dentist Review \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on Dec 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Barbara Wilson. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**(a) Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$ 2 for each page and the staff time charged will be \$ 20 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**(b) Right to Request Restriction of PHI:** You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where "the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**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, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

### YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$ 2 for each page and the staff time charged will be \$ 20 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**Breach Notification Requirements:** Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

### QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

### HOW TO CONTACT US

Practice Name: <u>Cordera Family Dentistry</u>	Privacy Officer: <u>Barbara Wilson</u>
Telephone: <u>(719) 494-2865</u>	Fax: <u>(719) 282-6091</u>
Address: <u>9235 N. Union Blvd, Unit 170, Colorado Springs, CO 80920</u>	
Email: <u>office@corderadental.com</u>	

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
*Please print your name here*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Employee signature*

\_\_\_\_\_  
*Date*

# It's About Expectations...

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We appreciate and value you as a patient in our practice. In order to maintain an excellent, mutually beneficial relationship, we would like to take this opportunity to reiterate our office expectations.

## **As a patient of our practice, you can expect us to:**

- ◆ Greet you in a friendly, professional manner.
- ◆ Seat you as soon after your arrival as possible.
- ◆ Outline the estimated cost associated with any treatment before beginning.
- ◆ Strive to perform painless dentistry.
- ◆ Provide the most advanced dental procedures and materials.
- ◆ Explain the treatment being performed.
- ◆ Maintain a clean office.
- ◆ Sterilize all instruments and disinfect all treatment rooms.
- ◆ Do everything possible to make you feel welcome and comfortable.
- ◆ Treat you with the utmost professionalism and personal attention.
- ◆ Assist you in assuring the processing of your insurance claims does not exceed eight weeks.
- ◆ Remind you of your scheduled appointments a day in advance.
- ◆ Treat any friends and family you refer to us with the same friendly, personal attention.

## **As a patient of our practice, we expect you to:**

- ◆ Keep your scheduled appointments. We require a two business day notice for any appointment changes to avoid a \$25 cancellation fee.
- ◆ Arrive on time for your appointments.
- ◆ If you have insurance, pay your estimated patient portion at the time services are rendered. There is a \$40.00 returned check fee.
- ◆ If you do not have insurance, pay for your services at the time they are rendered.
- ◆ Provide us with current and accurate insurance information.
- ◆ Keep us updated regarding changes in your personal information, such as address and telephone numbers.
- ◆ Notify us of changes of your general health status, including any special needs that you may have.
- ◆ Brush and floss daily as recommended by our staff.
- ◆ See us regularly for exams and cleanings as recommended by our doctors and staff.
- ◆ Feel comfortable referring your friends and family members to our office!

Signed \_\_\_\_\_

Patient

Signed \_\_\_\_\_

Cordera Family Dentistry

Date \_\_\_\_\_

Date \_\_\_\_\_

**Cordera Family Dentistry  
Hans Egbert D.D.S.  
Policy Form**

**Office Financial Policies**

Dental insurance plans do not normally provide full coverage of your dental bill. Your dental coverage is a contract between you and your insurance company, and while we will cooperate to the fullest in expediting your claim, you are ultimately responsible for your account. Estimates given through our office are NOT a guarantee of payment by your insurance company. **Your portion of the bill will be due at time of service.**

If your insurance has not been paid within 60 days from the date of service, we will look to you for prompt payment of the account. All costs for collection of the account including, but not limited to, interest, rebilling fees, court costs, attorney fees, and collection agency costs will be passed on to the patient and/or the responsible party.

I understand that intentionally providing false information in attempt to receive undue insurance benefits constitutes fraud and will be prosecuted as such.

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Signature

Date

**Insurance Regulations and Assignment of Benefits**

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health care information to carry out payment activities in connection with claims submitted from this office. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Cordera Family Dentistry.

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Signature

Date

### AUTHORIZATION TO RELEASE INFORMATION

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

May we leave a message on your:

**Home:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

Yes     No

Yes     No

Yes     No

Under HIPPA requirements, our practice is not allowed to give any of your personal information to anyone else without your consent. **Please sign below if you would like to authorize Cordera Family Dentistry to discuss appointment information, insurance correspondence, and/or procedure information with the following individual(s):**

1.) \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Is it ok to leave a message:     Yes     No

2.) \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Is it ok to leave a message:     Yes     No

3.) \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Is it ok to leave a message:     Yes     No

**Patient/Guardian Signature:** \_\_\_\_\_

**Relationship to Patient (if not patient):** \_\_\_\_\_