

■ Patient Information ■

Name: _____
Last First MI Title

Preferred Name: _____ Male Female

Address: _____

City _____ State _____ ZIP _____

SSN: _____ DOB: _____

Cell Phone: _____ Home Phone: _____

Do you prefer to be contacted for appointment confirmation via phone call or text message?

E-mail Address: _____

Marital Status: Single Married Divorced Widowed Child

How did you hear about our office? _____

■ Insurance – Primary ■

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Relationship: _____

Insurance Company Name: _____

Insurance Company Phone: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Reach Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Do you take daily aspirin: Yes No

Have you ever had any surgical procedures? Yes No

Please list each one: _____

Yes No Conditions

- Abnormal Bleeding
- Alcohol Abuse
- Anemia
- Angina Pectoris
- Anxiety
- Arthritis
- Artificial Heart Valve
- Artificial Joint
- Autism
- Auto Immune Conditions
- Asthma
- Back Problems
- Blood Transfusion
- Cancer
- Chemotherapy
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Epilepsy
- Fainting Spells
- Frequent Headaches
- Frequent Fainting
- Glaucoma

Yes No Conditions

- HIV+ AIDS
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Problems
- Low Blood Pressure
- Lupus
- Mitral Valve Prolapse
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Respiratory Disease
- Rheumatic Fever
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease

Yes No Conditions

- Sinus Problems
- Skin Rash
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

Yes No

- Aspirin
- Codeine
- Dental Anesthetics
- Latex
- Metals
- Penicillin
- Seasonal Allergies
- Sulfa
- Other _____

If Female, Please Answer

Yes No

- Are you taking Birth Control Pills?
- Are you pregnant? If so, # of Weeks _____
- Are you nursing

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Dental History

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Do your gums bleed? Yes No

How many times a do you: floss/week? _____ brush/day? _____

Are your teeth sensitive to heat, cold or anything else? Yes No

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

CONSENT OF SERVICES

I understand that the information that I have given is correct to the best of my knowledge. I hereby authorize the Dentist or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist to perform all recommended treatment mutually agreed upon and to employ such

assistance as required providing proper care. I agree to the use of anesthetics and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due at the time of service.

Signature _____ Date _____

FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- I understand that Insurance is a form of payment, but the total bill is my responsibility. Any fees given are only estimate from your dental insurance company.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- Treatment plans may change and I will be responsible for the work actually done.
- In case of a missed appointment or cancelled appointment (failing to inform office at least 24hrs in advance), you will be charged a \$50 fee.

Signature _____ Date _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature _____ Date _____

MISSED APPOINTMENTS

We require that you call the office 24 hours in advance to cancel/reschedule your appointment. The Office reserves the right to charge for missed appointments and those cancelled without proper notice. **There is a \$50 late cancellation/no show fee.** If you miss an appointment without proper notice you will be charged this fee.

Signature _____

Date _____

LATE SHOW APPOINTMENTS

If you are late to your appointment, we do not guarantee you will be seen. Your appointment may have to be rescheduled.

Signature _____

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/15/2013, 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 created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Security: You will be notified as soon as possible if the security of your personal health information is breached.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician, pharmacist, 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.



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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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. We will not use your information for fundraising purposes without authorization. We will disclose any financial conflicts of interests that may be involved with your treatment.

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

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative

proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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

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 practicably 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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$0.25 for each page to copy your health information, and postage if you want the copies mailed to you. If you request an 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. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide 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.

Non-disclosure to insurance company: If you pay out of pocket, in full, for a service or a procedure or service; we will not submit the claim for that service to your insurance company upon your request.

Electronic Notice: You may receive a paper copy of this notice upon request.

Questions and Complaints

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

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



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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.

Contact: [DreamSmile of Norcross](#)

Telephone: 770-449-1497

E-mail: smile@dsnorcross.com