376 DENTAL STUDIO
dentistry reimagined

Patient Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date: _____ Soc. Sec. # _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Tel: (_____) _____ Cell: (_____) _____

Employer: _____ Work Tel: (_____) _____

Emergency Contact _____ Tel: (_____) _____

Who Will be Responsible for Your Account?

❑ **Self (If self, skip this step)** ❑ Father ❑ Mother ❑ Other (Relation to you) _____

Name: _____ Soc. Sec. # _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Tel: (_____) _____ Cell: (_____) _____

Employer: _____ Work Tel: (_____) _____

Spouse or other Guarantor Information (If different from above)

Name: _____ Soc. Sec. # _____ Birth Date: _____

Relation: _____ Email: _____ Home Tel: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance

Insurance Type: ❑ Dental ❑ Medical

Subscriber Name: _____ Relation: _____

Subscriber Birth Date: _____

Susbsriber SSN _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Insurance Co. Name _____

Insurance ID # _____

Group Number _____

Group Name/Plan: _____

Secondary Insurance

Insurance Type: ❑ Dental ❑ Medical

Subscriber Name: _____ Relation: _____

Subscriber Birth Date: _____

Susbsriber SSN _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Insurance Co. Name _____

Insurance ID # _____

Group Number _____

Group Name/Plan: _____

Have you been a patient of our practice before? ❑ Yes ❑ No

How did you find our office (or whom may we thank for a referral)? _____

❑ Google Search ❑ Facebook / Social Media ❑ Brochure / Mail ❑ Other _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to 376 Dental Studio all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all necessary information to process my insurance claim.

X _____ *X* _____

Signature of patient (Parent or Guardian if Minor) Date

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Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays_____ _____

Address _____ City: _____ State: _____ Zip: _____

Check if you have problems with any of the following:

❑ Bad breath ❑ Bleeding gums ❑ Clicking or popping jaw ❑ Difficulty chewing ❑ Grinding teeth ❑ Spaces between teeth
❑ Loose teeth or broken fillings ❑ Sensitivity to cold ❑ Sensitivity to hot ❑ Sensitivity to sweets ❑ Sensitivity when biting
❑ Sores or growths in your mouth

How often to you floss? _____ How often do you brush? _____

Is there anything you would like to change about your smile?_____

Medical History

Physician's Name _____ Date of last visit _____

Do you currently (or have you in the past) taken any Bisphosphonates (e.g. Boniva, Fosamax, Actonel)? ❑ Yes ❑ No

Have you had any serious illnesses or operations? ❑ Yes ❑ No If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates _____

Women Only: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control? ❑ Yes ❑ No

Check if you have problems with any of the following:

❑ Anemia
❑ Arthritis, Rheumatism
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Back Problems
❑ Blood Disease
❑ Cancer
❑ Chemical Dependency
❑ Chemotherapy
❑ Circulatory Problems
❑ Cortisone Treatments
❑ Cough, Persistent
❑ Cough up Blood
❑ Diabetes
❑ Epilepsy
❑ Fainting
❑ Glaucoma
❑ Headaches
❑ Heart Murmur
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ HIV/AIDS
❑ Jaw Pain
❑ Kidney Disease
❑ Liver Disease
❑ Mitral Valve Prolapse
❑ Pacemaker
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Shortness of Breath
❑ Skin Rash
❑ Stroke
❑ Swelling of Feet or Ankles
❑ Thyroid Problems
❑ Tobacco Habit
❑ Tonsillitis
❑ Tuberculosis
❑ Ulcer
❑ Venereal Disease

Medications

List medications you are currently taking below:

_____

_____

_____

Allergies

❑ Penicillin
❑ Sulfa Drugs
❑ Local Anesthetic
❑ Latex
❑ Aspirin
❑ Codeine
❑ Metals
❑ Other _____

Providing incorrect information can be dangerous to your health. Please sign below to indicate you have completed this medical history form to the best of your knowledge and ability.

X _____
Signature of patient (Parent or Guardian if Minor)

X _____
Date

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Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Payments are expected at the time services are rendered. We accept cash, debit cards, and all major credit cards. Please see payment plan options below:

Optional Payment Terms

1. **Full Pay Cash Discount for Non-Insurance patients:** We offer a 10% courtesy for all treatment that is paid in full (cash or credit card) at the time of service.

2. **Major Service - Two Payment Option:** We offer a two-payment option for Crown, Bridge, Implant, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half on the date when your prosthesis is delivered.

3. **Credit Card Payment Option:** We allow (with a signed agreement form and established payment history with our office), a Credit Card Payment Option, which allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office personnel will charge these payments to your credit card on the due dates.

4. **Term Loan:** By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

Broken Appointments

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $35.00 cancellation fee (emergencies are an exception).

X _____ *X* _____

Signature of patient (Parent or Guardian if Minor) Date

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HIPAA Privacy Form
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.

Our Legal Duty

The privacy of your health information is important to us. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this 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 this Notice while it is in effect. This Notice takes effect 4/1/2013, 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 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 connection 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 for 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 Rights 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.

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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 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, or 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 or 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 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 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 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. 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 request copies, we will charge you a nominal fee for staff time to locate and 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 inthat 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. 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 satisfactory explanation 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 mail (e-mail), you are entitled to receive this Notice in written form.

Acknowledgement of Receipt of Notice of Privacy Practices (previous 2 pages)

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)