Broadhollow Dentistry

Patient Name: _____ Todays Date: _____
Last First MI

How would you like our staff to address you? _____

Male ___Female ___

Married ___ Single ___ Child ___ Other ___

Social Security #: _____ Date of Birth: _____

Phone # (Home): _____ Work: _____ Cell: _____

Email: _____ Home Address: _____

Pharmacy (include address and phone #): _____

Health Information

Have you **ever** had any of the following? Please check **ALL** that apply:

__AIDS
__ALLERGIES
__ANEMIA
__ARTHRITIS
__ARTIFICAL JOINTS
__ASTHMA
__BLOOD DISEASE
__CANCER
__DIABETES
__DIZZINESS
__EPILEPSY
__EXCESSIVE BLEEDING
__FAINTING
__GLAUCOMA
__GROWTHS

__HAY FEVER
__HEAD INJURY
__HEART DISEASE
__HEART MURMUR
__HEPATITIS
__HIGH BLOOD PRESSURE
__JAUNDICE
__LIVER DISEASE
__MENTAL DISORDERS
__NERVOUS DISORDERS
__PACEMAKER
__PREGNANCY
^^DUE DATE: _____
__RADIATION TREATMENT
__RESPIRATORY PROBLEMS

__RHEUMATIC FEVER
__RHEUMATISM
__SINUS PROBLEMS
__STOMACH PROBLEMS
__STROKE
__TUBERCULOSIS
__TUMORS
__ULCERS
__VENEREAL DISEASE
__CODEINE ALLERGY
__PENICILLIN ALLERGY
__THYROID DISORDER
__LATEX SENSITIVITY

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

__LOCAL ANESTHETICS
__ASPIRIN
__CODEINE, VALIUM, OTHER SEDATIVES?

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____
_____

OTHER ALLERGIES: _____
_____
_____

Have you ever had any complications following dental treatment: ___yes ___ no
If yes, please explain: _____
_____
Have you been admitted to a hospital, needed emergency care or have you had any surgeries in the last two years?
___yes ___no
If yes, please explain: _____
_____
Are you currently under the care of a physician? ___yes ___no
If yes, please explain: _____
Name of physician: _____ Phone: _____
Have you ever needed to take antibiotic prior to dental treatment? ___yes ___no
If yes, please explain: _____
ARE YOU CURRENTLY TAKING A BLOOD THINNER? ___YES ___NO
IF YES, **START DATE/REASON**: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform my providers in this office at the next appointment without fail.

X_____ Date: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Fees are due at the time of service**.

A late fee of $10.00 per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

As per our Cancellation Policy, **any missed or cancelled appointments without 24 hour notice will incur a $50.00 fee.**

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. **Patient is responsible for all fees accumulated if account is sent to collections.**

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

HIPAA PRIVACY FORM

NOTICE OF PRIVACY PRACTICES

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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 OUR HEALTH INFORMATION IS IMPORTANT TO US.

Our legal duty: 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 (01/01/2003), 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 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 HEATH 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 obtain payment for services we provide to you. **Payment:** 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 Patients 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 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, our 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 use or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practices to make reasonable references of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

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 or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

  _____
  _____