

PATIENT INFORMATION AND INSURANCE FORM

Patient Name:	Preferred Name:				
Home Phone:	Cell Phone:	Email:			
Date of Birth: / /	Social Security:	Ger	nder: Male	Fem	ale
Address:					
City:	Zip Code:	Drivers Licer	nse #		
Marital Status: Single	Married	Divorced	Widowed		
Emergency Contact:		Phone:			
Employer:		Phone:			
May we contact you at work?	Responsible Party	:			
	<u>DENTAL</u> INSURANCE IN	IFORMATION			
Primary:	Group #	up #Policy/ID #:			
Subscriber Name:		Relation to patie	ent:		
Subscriber Address:					
Subscriber Phone:	Subscriber DOB:		Sex:	Male	Female
Subscriber Employer:	iber Employer:Subscriber Social Security				
	MEDICAL INSURANCE I	NFORMATION			
Primary:	Group #	Polic	cy/ID #:		
Subscriber Name:		Relation to patie	ent:		
Subscriber Address:					
Subscriber Phone:	Subscriber DOB:		Sex:	Male	_Female
Subscriber Employer:		Subscriber Social Se	ecurity		



I certify that the information contained in the "Patient Information and Insurance Form" are true, complete and correct to the best of my knowledge.

. . .		
Signature of Patient o	r Resnonsible Party:	
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Printed Name:	Date:	1	1
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Patient Name

Date

SYSTEMIC HEALTH: (Do you currently have, or have been previously treated for, any of the following conditions?)

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SKIN	Current	Previous
Itching, Rash, Ulcers		
Pigmentations		
Lack or loss of body hair		
EXTREMITIES	Current	Previous
Swollen, painful joints		
Muscle weakness, pain		
Bone deformity, fracture		
Prosthetic joints		
EYES	Current	Previous
Blurring of vision		
Double vision		
Drooping of eyelid		
Glaucoma		
EAR, NOSE, THROAT	Current	Previous
Earache		
Hearing loss		
Frequent nosebleeds		
Sinusitis		
Frequent sore throat, hoarseness		
Dry mouth		
RESPIRATORY	Current	Previous
Cough blood in sputum		
COPD, emphysema, bronchitis		
Asthma, wheezing		
Tuberculosis, exposure to		
CARDIAC	Current	Previous
Shortness of breath		
Swelling of ankles		
Mitral valve prolapse, murmur		
Pain, pressure in chest, angina		
High, low blood pressure		
Rheumatic, Scarlet fever		
Heart attack. Tallure		
Heart attack, failure Heart surgery, stents, bypass		
Heart surgery, stents, bypass		
Heart surgery, stents, bypass Prosthetic valve, pacemaker		
Heart surgery, stents, bypass Prosthetic valve, pacemaker Other heart disease		Bread
Heart surgery, stents, bypass Prosthetic valve, pacemaker Other heart disease GASTROINTESTINAL	Current	Previous
Heart surgery, stents, bypass Prosthetic valve, pacemaker Other heart disease GASTROINTESTINAL Difficulty swallowing	Current	Previous
Heart surgery, stents, bypass Prosthetic valve, pacemaker Other heart disease GASTROINTESTINAL Difficulty swallowing Abdominal pain, ulcers	Current	Previous
Heart surgery, stents, bypass Prosthetic valve, pacemaker Other heart disease GASTROINTESTINAL Difficulty swallowing	Current	Previous

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Alcohol or chemical dependency	Crohn's disease		
· · · · · · · · · · · · · · · · · · ·	Fibromyalgia		
Organ transplant	Alcohol or chemical dependency		
	Organ transplant		



Name:	Date:	
If the person completing this form is someone other than the patient, what is his/her relationship to the patient?		
DENTAL HISTORY:		
When was your last visit to the dentist?		
What was the reason for your last visit?		
Have you had any difficulties with past treatment?		
Do you take antibiotics before every dental appointment (pre	medicate)?Why?	
FAMILY HISTORY:		
Have any members of your family ever been diagnosed or tr	eated for the following conditions?	
Diabetes?High Blood Pressure?Heart Probler	ns?Depression or Bipolar Disorder?	
Gum Disease?Seizures?		
Do any of your family members wear dentures?	Relationship?	
SOCIAL HISTORY:		
Do you or have you ever smoked? How many cigaret	tesper day? How many years?	
How often do you drink alcohol? Ot		
MEDICAL HISTORY:		
Are you now or have you been under the care of a physiciar	during the past 12 months?	
Date of last visit with physician:Reason for la		
Physician's Name:		
Have you been to the hospital or had an inpatient/outpatient		
Procedure?	Date:	
Allergies or Sensitivities: Latex or Acrylics?Antibiotics		
Local anesthetic (Novocaine)?Codeine or other narco	tic?Sulfa drugs?Other?	
Females: Oral contraceptives?Could you be pr	egnant?Are you nursing?	
Do you take any medications at the present time? (Circle) Y	/ N	
MEDICATIONS: (If you are taking more than five medi	cations, please provide us with a current list)	
	DSAGE	
1		
2.		
3.		

4. _____

5. _____



Please use the following space to clarify or explain, in your own words, any medical conditions, medications, allergies, inpatient/outpatient procedures from the previous two pages. Also use this space to add any medical conditions or information not listed on previous pages:

(If more space is needed, please request another piece of paper from the front desk)

To the best of my knowledge, the questions on these forms have been accurately answered. This includes the list of medical conditions (page 3), as well as medications I am currently taking and all known allergies to medications or allergies to anything else (page 4), and any additional clarifying information above. I understand that incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the doctor of changes in medical and dental statuses that occurs between appointments.

Signature of patient, parent or guardian:

Date:



INSURANCE AGREEMENT

***Whether you have dental insurance or not ***, we ask that you review and sign our insurance agreement. Occasionally a patient's insurance status will change and we wish you to understand our policy in advance.

To our patients who are requesting that we file their insurance: this form must be read, understood and signed by the responsible party before we can accept payment directly from an insurance company.

- 1. Patients who carry dental insurance should remember that professional services are rendered and charged to the patient and not to the insurance companies. You are responsible for the payment of all treatment fees on your account. If your insurance company fails to pay or fails to pay within <u>60</u> days, you will be responsible to pay your account in full.
- 2. Our office will file, but does not accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your account.
- 3. It is your sole responsibility to know the terms and agreements of your dental insurance benefit contract.
- 4. Our office cannot make a totally accurate estimate of your insurance benefits to be paid since we do not have access to all of your insurance records. Also, it is our experience that many insurance companies are not completely consistent with what they will and will not cover.
- 5. Upon payment by your insurance company, if there is a remaining balance, it is due and to be paid in full at the time of billing.

Signature of Responsible Party

Date



SIGNATURE RELEASE STATEMENT

YOUR SIGNATURE IS NECESSARY FOR US TO:

- 1. PROCESS ALL INSURANCE CLAIMS.
- 2. ENSURE PAYMENT FOR SERVICES PROVIDED.
- 3. RELEASE MEDICAL INFORMATION TO INSURANCE COMPANIES NEEDED FOR THE PROCESSING OF YOUR CLAIMS.

4. RELEASE INFORMATION TO OTHER MEDICAL AND DENTAL PROVIDERS, INCLUDING LABORATORIES, WHEN NECESSARY, FOR YOUR TREATMENT.

I hereby authorize the release of all medical information necessary to process my claims and I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make a diagnosis or fabricate an appliance necessary for my treatment.

I authorize and request my insurance company to pay directly to Dr. Harold Henderson/PV Dentistry any health benefits resulting from care received in that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and agree to assume responsibility for any services not covered. I further agree to pay all finance charges, collection costs, attorneys fees, and other cost that may be incurred to enforce collection of any amount outstanding. I consent to the release to my insurance company any medical record necessary to resolve claims for services rendered. I understand co-pays and any services not covered by an insurance company are <u>DUE IN FULL AT THE TIME OF</u> <u>SERVICE.</u> I assign all medical benefits, including diagnostic and surgical benefits and major medical benefits to which I am entitled, to Dr. Harold Henderson/PV Dentistry. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Any unpaid balance will be subject to a 1.5% monthly interest charge.

Patient Signature	Printed Name:
Parent Signature (if minor)	
Witness	Date: / /



PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with utmost professional and excellence of service. Our commitment to your well being is something everyone in our practice takes seriously. Because we care about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive.

We expect you to keep all appointments. In most cases, we will give an appointment card with the time and date of your scheduled visit. We will also attempt to make a reminder call on the business day prior to your appointment.

With the exception of serious emergencies, it is expected that you will keep your appointments. If you need to reschedule an appointment we require **<u>A FULL BUSINESS DAYS NOTICE</u>**. This means communicating with us during business hours and not leaving a cancellation notice on the answering machine.

In the instance of a cancellation without the full business days notice or a **NO-SHOW** to a scheduled appointment, we reserve the right to charge you a **FEE**. In instances of repeated non-compliance with your scheduled visits, we will withdraw from seeing you for your Dental Care. This does not exempt you of your financial responsibilities.

I have read and understand this policy.

Patient/parent/guardian signature

Date



NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment, and Health Care Operations.

- <u>Treatment</u> means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include specialty or hygiene services.
- <u>Payment</u> means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- <u>Health Care Operations</u> include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information. We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Policy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information from us by alternate means or at alternate locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Pricy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below. We will not retaliate against you for filing a complaint.

Please feel free to contact us for more information if you would like.



OUR PRIVACY PLEDGE

Because we value you as our patient we are concerned with protecting your privacy. While the law requires us to give you the attached disclosure, please understand that we have, and always will, respect the privacy of your health information.

The staff at this office has received and reviewed the Health Information Privacy Policies and Procedures in compliance with the Health Insurance Portability and Accountability Act (HIPAA) that became effective April 15, 2003.

We appreciate your taking time to read and review and sign the following documents: Notice of Privacy Practices Insurance Agreement Signature Release Statement

In signing this you agree to the existing practices of this office regarding record storage, charting practices, documentation, and daily operations of this practice. You agree to allow PV Dentistry to use and disclose pertinent health information for medical purposes, billing purposes and laboratory purposes. You also agree to continue receiving the mailed hygiene recall postcards and/or our courtesy calls for your appointments that may be left on your answering machine.

I have read the above mentioned policies and agree to its terms. I am also acknowledging that I have received copies of these documents to take home with me, and have also signed and dated those documents.

Signature

Date

Printed name