PATIENT REGISTRATION

First Name: ________________________________ Last Name: ___________________________________

Address: ____

City, State, Zip Code: ____

Home Phone: ______________________________ Cell Phone: _____________________________________

Work Phone: ___________________ How did you hear about us? ___________________________________

Email: ____________________________________ I would like to receive email correspondence: **YES** / **NO**

Social Security: ________________________ DOB: _____/______/______ DL#: ____________________

Emergency Contact: ____ Phone: _______________________

Sex: **M** or **F** Marital Status: child single married divorced separated widowed partnered

Primary Insurance Information:

Name of Insured: _____________________________ Relationship to Patient: ______________________

DOB of Insured: ______________________________ Social Security # of Insured:___________________

Insured's Employer: ___________________________ Employer Phone: ___________________________

Insurance Company: ____________________________ Insurance Phone: __________________________

Please read carefully below:

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE ALL NEEDZ DENTAL TO PERFORM ANY AND ALL FORMS OF TREATMENT AND OR MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTETHIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND ALL NEEDZ DENTAL, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO ALL NEEDZ DENTAL AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

____ ______________________________

Patient Signature Date

____ ______________________________

Parent/Guardian Signature Date

Patient Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? Yes No If yes, explain: ___________________________________
Have you ever been hospitalized? Yes No If yes, explain: ___________________________________
Have you had a major operation? Yes No If yes, explain: ___________________________________
Have you had a serious head/neck injury? Yes No If yes, explain: ___________________________________
Do you take any medication, pills or drugs? Yes No If yes, explain: ___________________________________
Do you take any blood thinners? Yes No If yes, explain: ___________________________________
Have you taken Phen-Fen or Redux? Yes No ___________________________________
Are you on a special diet? Yes No ___________________________________
Do you use tobacco products? Yes No
Do you use controlled substances? Yes No
Do you snore? Yes No
Have you been diagnosed with sleep apnea? Yes No

Women:
Taking oral contraceptives/birth control? **Y N**
Pregnant/trying to conceive? **Y N**
Nursing? **Y N**

Are you allergic to any of the following (please circle ALL that apply)? If no known drug allergies, circle NONE.

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs NONE

Other Allergies: ____

Do you have or have you had any of the following? Circle all that apply

AIDS / HIV Positive	Cold Sore/Fever Blister	Glaucoma	Liver Disease	Stomach/Intestinal Disease
Alzheimer's Disease	Congenital Heart Disorder	Hay Fever	Low Blood Pressure	Stroke / TIA
Anaphylaxis	Convulsions	Heart Attack / Failure	Lung Disease	Swelling of limbs
Anemia	Cortisone Medications	Heart Murmur	Mitral Valve Prolapse	Thyroid Disease
Angina	Diabetes	Heart Pace Maker	Pain in Jaw Joints	Tonsillitis
Arthritis / Gout	Drug Addiction	Heart Trouble / Disease	Parathyroid Disease	Tuberculosis
Artificial Heart Valve	Easily Winded	Hemophilia	Psychiatric Care	Tumors or growths
Artificial Joint(s)	Emphysema	Hepatitis A	Radiation Treatments	Ulcers
Asthma	Epilepsy or Seizures	Hepatitis B or C	Recent Weight Loss	Venereal Disease
Blood Disease	Excessive Bleeding	Herpes	Renal Dialysis	Yellow Jaundice
Blood Transfusion	Excessive Thirst	High Blood Pressure	Rheumatic Fever	High Cholesterol
Breathing Problems	Fainting Spells/Dizziness	Hives or Rash	Rheumatism	Osteoporosis
Bruise Easily	Frequent Cough	Hypoglycemia	Scarlet Fever	Spina Bifida
Cancer	Frequent Diarrhea	Irregular Heartbeat	Shingles	
Chemotherapy	Frequent Headaches	Kidney Problems	Sickle Cell Disease	
Chest Pains	Genital Herpes	Leukemia	Sinus Trouble	

Have you had any serious or chronic illness not listed above? Yes No Explain: ______________________________

Comments:____
____
____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or patients') health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient: ____ Date: _________________________________

Signature of parent/Guardian: ________________________________ 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 & Accountability Act of 1996 (“HIPAA”) is a federal program that requires 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. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment 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.
- Healthcare operations 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 individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that maybe of interest to you.

Any other uses and disclosures will be made only with your written 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 Privacy
Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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 October 17, 2002 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 Privacy 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, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

○ I DO NOT authorize any information to be discussed with any family members or friends.

○ I authorize information about treatment or appointments to be discussed with the following person(s):
____

I have read and understand the above information.

SIGNATURE OF PATIENT: ____ DATE: ______________________________

SIGNATURE OF PARENT/GUARDIAN: ____________________________________ DATE: ______________________________

ALL NEEDZ DENTAL BILLING PROCESS

Thank you for choosing All Needz Dental! In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with you dental insurance, we call your insurance company and verify your benefits. The information we receive from your insurance company is only an estimation of coverage and is NOT a guarantee of payment. After you have been seen in our office, we will file your claim to the insurance company directly. If the insurance company DOES NOT cover the estimated amount in full, you will receive a statement in the mail from our office and you are responsible for the remaining account balance. Thank you again for choosing All Needz Dental for your dental needs. We look forward to a long lasting relationship with you and your family.

I HAVE READ AND UNDERSTAND THE BILLING PROCESS AT All Needz Dental.

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PATIENT/PARENT/GUARDIAN NAME (PRINTED)

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PATIENT/PARENT/GUARDIAN SIGNATURE ***DATE***

PRACTICE POLICIES

Our goal is to provide quality dental care in a timely manner. In order to do so we have had to implement a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need OF CARE.

CANCELLATION OF AN APPOINTMENT: In order to be respectful of other patients' needs, please call our office promptly if you are unable to attend an appointment. We ask that you call 24 hours in advance to reschedule/cancel. A no show/no call will result in a cancellation fee.

NO SHOW POLICY: A "no show" is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of $50 for every half hour scheduled.

LATE ARRIVALS: In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

CELL PHONE POLICY As a courtesy to other patients and in an effort to maintain our schedule, we request that cell phones be put away while the doctor, hygienist, or assistant is in the room with you.

I HAVE READ AND UNDERSTAND THE "PRACTICE POLICIES"

____

PATIENT/PARENT/GUARDIAN NAME (PRINTED)

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PATIENT/PARENT/GUARDIAN SIGNATURE ***DATE***