



PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____
Previous Dentist: _____
Emergency Contact: _____
Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Health History Form



American Dental Association
www.ada.org

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:	Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>
Last First Middle	()	()
Address:	City:	State: Zip:
<small>Mailing address</small>		
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone:
		() () <small>Include area codes</small>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems:	<i>(Check DK if you Don't Know the answer to the question)</i>	Yes	No	DK
Active Tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i>				If yes, what was the illness or problem?			
Address/City/State/Zip:							
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
If yes, what condition is being treated?							
Date of last physical exam:							

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p>(Check DK if you Don't Know the answer to the question)</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</p>	<p>Do you use controlled substances (drugs)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED</p>
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<p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actone®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p>
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<p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____</p>	<p>WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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<p>Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Metals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Animals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p>Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, specify: _____ Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify: _____ Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Type of infection: _____ Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Severe headaches/ migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p>Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____ Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Name of physician or dentist making recommendation: _____ Phone: _____</p> <p>Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Please explain: _____</p>
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NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

NOTICE OF PRIVACY PRACTICES

Dee for Dentist
Rewadee Meevasin, DMD
8772 S. Maryland Pkwy, Suite 100 • Las Vegas, Nevada 89123
(702) 586.7800 tel • (702) 586.7575 fax
info@deefordentist.com

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record
 - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
 - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
 - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
 - We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
 - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
 - We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share
 - You can ask us not to use or share certain health information for treatment, payment, or our operations.
 - We are not required to agree to your request, and we may say "no" if it would affect your care.
 - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
 - We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information
 - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
 - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice
 - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
 - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
 - We will make sure the person has this authority and can act for you before we take any action.

- File a complaint if you feel your rights are violated
 - You can complain if you feel we have violated your rights by contacting us using the information at the top of Page 1.
 - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/.
 - We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to:
 - Share information with your family, close friends, or others involved in your care
 - Share information in a disaster relief situation
 - Include your information in a hospital directory
 - Contact you for fundraising efforts
 - If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
 - Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
- In the case of fundraising:
 - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- Treat you
 - We can use your health information and share it with other professionals who are treating you.
 - Example: A doctor treating you for an injury asks another doctor about your overall health condition
- Run our organization
 - We can use and share your health information to run our practice, improve your care, and contact you when necessary
 - Example: We use health information about you to manage your treatment and services
- Bill for your services
 - We can use and share your health information to bill and get payment from health plans or other entities
 - Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health safety issues
 - We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety
- Do research
 - We can use or share your information for health research.
- Comply with the law
 - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donor requests
 - We can share health information about your organ procurement organizations
- Work with a medical examiner or funeral director
 - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
 - We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
 - We can share health information about you in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health formation.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html.

Changes to the Terms of This Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dee for Dentist's Notice of Privacy Practices

Patient Name (Please print)

Patient, Parent or Guardian Signature

Date



AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient address _____

Patient phone number _____

I authorize Dee for Dentist to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

- 1. Detailed description of the information to be released: Information relating to patient treatment.
- 2. To whom may the information be released: Patient's insurance carrier, Patient's spouse Patient's parents. Additional persons: _____
- 3. The purpose(s) for the release: For purposes relating to treatment and payment for services. Additional purposes: _____
- 4. Expiration date or event relating to the individual or purpose for the release: Open ended unless expiration date entered: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____

OFFICE POLICIES

Appointments & Deposits:

- I understand that at Dee for Dentist the appointment is considered the confirmation. Although I may receive reminders, by setting the appointment I am making a commitment to a portion of time specifically for me, making it unavailable for other patients.
- As a courtesy, I will notify Dee for Dentist if I cannot make an appointment at least 48 hours prior to the scheduled time. Missed or late cancelled appointment may be subject to a fee of \$50 per hour scheduled.
- For patients with a history of missing or cancelling appointments at the last minute, Dee for Dentist reserves the right to double-book future appointments. Dee for Dentist will try to keep the time open for me, however they may schedule other patients to ensure that the time slot is filled and not wasted. Should my appointment be double-booked, I understand that Dee for Dentist will treat the other patient first, which may result in my appointment needing to be rescheduled.
- For patients with a history of missing or cancelling appointments at the last minute, I understand that Dee for Dentist may require a deposit to secure future appointments.

Dental Insurance:

- I understand that my insurance is a contract between me and my insurance company. Dee for Dentist is NOT a part of that contract.
- I understand that not all services are covered benefits in all contracts. Some insurance companies arbitrarily select services they will and will not cover.
- I understand that if my insurance carrier does not pay the estimated benefit in full, I will be immediately responsible for any remaining balance.
- If Dee for Dentist does not receive payment from the insurance carrier within 60 days, I will be responsible for payment of any treatment fees and collection of benefits directly from my insurance carrier.

Financial Policy:

- Forms of payment accepted at Dee for Dentist:
 - Cash
 - Credit Cards (Visa, MasterCard, Discover, American Express & Care Credit)
 - 3rd Party Financing and Payment Plans
- I understand that all co-pays and patient portions must be paid at the time of scheduling any treatment appointments.
- If I choose to discontinue care before treatment is complete, I may receive a refund less the cost of care received and any other non-refundable parts or supplies that were part of any future treatment.



Payment & Collections:

- I acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. In the event that I do not pay for performed services, Dee for Dentist may place my account with a collection agency. I further agree to pay reasonable collection fees, attorney fees and court costs incurred in collection of an overdue account.

Photos & Images:

- I authorize Dee for Dentist to take photographs, x-rays, and/or videos of my face, jaws, and teeth as a record of my care.
- I authorize Dee for Dentist to use photos of a non-clinical nature for their website or social media with the following exceptions:
 - I do not wish to have my First Name shown or released
 - I do not wish to have my entire face shown
 - I only agree to have my teeth shown without any identifying features
- I do not expect compensation, financial or otherwise, for the use of these photographs.

Responsible Party:

- As the responsible party, in the case where my spouse and/or children are also patients at Dee for Dentist, signing this Office Policies form will apply to them and their accounts as well.

Signature of Responsible Party/Cardholder

Date

Print Name of Responsible Party/Cardholder

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