PATIENT REGISTRATION FORM

Patient Name _____ **Date** _____

❑ Single ❑ Married ❑ Widowed ❑ Divorced

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

Social Security Number _____ Birth Date _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Person Responsible for Account _____

Dental Insurance Group _____ Group # _____

Employee Name _____

Social Security Number _____ Birth Date _____

Emergency Contact _____

Home Phone _____ Business Phone _____ Cell Phone _____

Referred to us by _____

Reason for leaving your last dentist _____

_____

_____

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MEDICAL QUESTIONNAIRE

Any History of:

Heart Problems ..... ❑ YES ❑ NO	Bronchitis ..... ❑ YES ❑ NO	Heart Valve Problems ..... ❑ YES ❑ NO
High Blood Pressure ..... ❑ YES ❑ NO	Fever Blisters/Herpes ..... ❑ YES ❑ NO	Nose Obstruction ..... ❑ YES ❑ NO
Rheumatic Fever ..... ❑ YES ❑ NO	Stroke ..... ❑ YES ❑ NO	Hypoglycemia ..... ❑ YES ❑ NO
Emotional Stress ..... ❑ YES ❑ NO	Thyroid Problems ..... ❑ YES ❑ NO	Hyperglycemia ..... ❑ YES ❑ NO
Asthma ..... ❑ YES ❑ NO	Sinus Trouble ..... ❑ YES ❑ NO	Prostate Problems ..... ❑ YES ❑ NO
Blood Transfusions ..... ❑ YES ❑ NO	Kidney or Liver Disease ... ❑ YES ❑ NO	Lung Disease ..... ❑ YES ❑ NO
Hepatitis ..... ❑ YES ❑ NO	Glaucoma ..... ❑ YES ❑ NO	Contact Lenses ..... ❑ YES ❑ NO
Artificial Joints ..... ❑ YES ❑ NO	Allergies ..... ❑ YES ❑ NO	Cancer ..... ❑ YES ❑ NO
Heart Murmur ..... ❑ YES ❑ NO	Prolonged Bleeding ..... ❑ YES ❑ NO	Ulcers ..... ❑ YES ❑ NO
Cortisone or ACTII ..... ❑ YES ❑ NO	Epilepsy/Convulsions ..... ❑ YES ❑ NO	Emphysema ..... ❑ YES ❑ NO
Anemia ..... ❑ YES ❑ NO	Arthritis ..... ❑ YES ❑ NO	Fainting or Dizzy Spells .... ❑ YES ❑ NO
Tested Positive for HIV ... ❑ YES ❑ NO	Diabetes ..... ❑ YES ❑ NO	Epinephrine Sensitivity ... ❑ YES ❑ NO

Do you have, or have you had, any diseases, conditions or problems not listed?

If yes, please specify: _____

Are you being treated by a physician now or have in the last six months? ❑ YES ❑ NO

Your Physician's Name _____

Are you taking any medications? ❑ YES ❑ NO *(This includes over-the-counter drugs and prescription drugs)*

If yes, please specify: _____

Are you allergic to any medications? ❑ YES ❑ NO *If yes, please specify:* _____

Any recent serious illnesses? ❑ YES ❑ NO *If yes, please specify:* _____

For women only: Are you pregnant? ❑ YES ❑ NO If yes, what month? _____

Are you nursing? ❑ YES ❑ NO

Are you on birth control? ❑ YES ❑ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

Consent:

I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective healthcare provider or agency who may release such information to you. I will notify this office of any changes in my health or medication. The undersigned hereby authorizes this office to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangement have been made. I further understand that a $1^{1/2}\%$ finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I/We promise to pay legal interest on indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. All diagnostic aids and documentation are the property of this office. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another dentist. I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

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DENTAL QUESTIONNAIRE

Last _____ First _____ MI _____ Nickname _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? ❑ YES ❑ NO
2. Have you ever had any problems associated with previous dentistry? ❑ YES ❑ NO
3. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely
4. Date of your last dental visit? _____
5. Have you ever been treated for any type of gum problems? ❑ YES ❑ NO
6. How often do you brush? _____ Brush is: ❑ Soft ❑ Medium ❑ Hard
7. Are you happy with the appearance of your teeth? ❑ YES ❑ NO
   If no, what would you change? _____
8. Do you have, or have you ever had, any of the following?

Mouth Problems:

Bleeding/sore gums ❑ YES ❑ NO
Unpleasant taste/bad breath ❑ YES ❑ NO
Burning tongue/lips ❑ YES ❑ NO
Frequent blisters/lips/mouth ❑ YES ❑ NO
Swelling/lumps in mouth ❑ YES ❑ NO
Ortho treatment (braces) ❑ YES ❑ NO
Biting cheeks/lips ❑ YES ❑ NO
Clicking/popping jaw ❑ YES ❑ NO
Difficulty opening or closing jaw ❑ YES ❑ NO
Headaches ❑ YES ❑ NO
Change in bite ❑ YES ❑ NO

Teeth Problems:

Loose teeth ❑ YES ❑ NO
Sensitive to hot ❑ YES ❑ NO
Sensitive to cold ❑ YES ❑ NO
Sensitive to sweets ❑ YES ❑ NO
Sensitive to biting ❑ YES ❑ NO
Food stuck in teeth ❑ YES ❑ NO
Clenching/grinding ❑ YES ❑ NO
If so, when _____
Shifting in bite ❑ YES ❑ NO
Change in bite ❑ YES ❑ NO

9. Do you use the following?

Brush ❑ YES ❑ NO
Fluoride Rinse ❑ YES ❑ NO
Dental Floss ❑ YES ❑ NO
Other _____

10. How would you rate your dental health? ❑ Excellent ❑ Good ❑ Poor
11. Any concerns or questions you have? _____

_____

These are things that are important to me about my dental health:

_____

_____

_____

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Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Submit by Email

Revised Oct 2014

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.
IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT THE PRIVACY OFFICER.

Jodi L. Pierce
HIPAA Officer

Effective Date: April 14, 2003 Revised: September 01, 2013

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or healthcare operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: edgertonandfisher.com

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USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time with another physician or healthcare provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called healthcare operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

If required by law:
The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.

Public health activities:
The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

Health oversight agencies:
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs and civil rights laws.

Legal proceedings:
To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.

Police or other law enforcement purposes:
The release of PHI will meet all applicable legal requirements for release.

Coroners, funeral directors:
We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

Medical research:
We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Special government purposes:
Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

Correctional institutions:
Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.

Worker's Compensation:
Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similarly legally-established programs.

Other uses and disclosures of your health information.

Business Associates:
Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange:
We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities:
We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives:
We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders:
We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object:

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgement will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psycotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

YOUR PRIVACY RIGHTS

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

Release of psychotherapy notes: Psycotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a healthy plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occured after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

ADDITIONAL PRIVACY RIGHTS

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

COMPLAINTS

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Jodi L. Pierce
HIPAA Officer
jodi@edgertonandfisher.com
910-256-9230

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2013.