River Hills Dental

Patient Information (Confidential)

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Social Security # _____

Home Phone _____ Cell Phone _____ E-mail _____

Employer _____ Work Phone _____

How do you prefer to be reminded of your appointments:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail ☐ Text message

Person to contact in case of emergency _____ Phone _____

How did you hear about us? _____

If the patient listed above is not the person responsible for the account, please complete this section:

Name of Responsible Person _____ Relationship to Patient _____

Birthdate _____ Employer _____ Work Phone _____

Social Security # _____ Is this person a patient in our office? ☐ Yes ☐ No

If patient address above is not the billing address, please complete address line below:

Address _____ City _____ State _____ Zip _____

Acknowledgement of Receipt of Notice of Privacy Practices & Authorization for Verbal Communication of Health information

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), River Hills Dental, P.A. must have your specific authorization to share any of your Protected Health information (PHI) with a spouse or family member. This is especially helpful in case there is an urgent need to contact you, if you need to reschedule an appointment and you are not available when we call, if there is someone who assists with your finances, or if someone other than yourself makes appointments for you. These people will not be authorized to disclosure of any of your written health information. You may change or revoke this authorization at any time. Anyone who is financially responsible for your account is entitled to your patient information.

Verbal Communication Regarding my Treatment can be Shared With (please print):

Name and Relationship	Phone Number	Type of Information
_____/_____	_____	☐ All ☐ Limited to: _____
_____/_____	_____	☐ All ☐ Limited to: _____
_____/_____	_____	☐ All ☐ Limited to: _____
_____/_____	_____	☐ All ☐ Limited to: _____

Be signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify) _____

River Hills Dental

Medical History

Patient Name _____

Medical Doctor _____ Office Phone _____ Date of Last Physical Exam _____

	Yes	No
1. Are you under the care of a physician?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
4. Have you ever taken any medicatons for bone loss or osteoporosis?	☐	☐
5. Do you use tobacco in any form?	☐	☐
6. Do you use recreational drugs?	☐	☐
7. Are you wearing contact lenses?	☐	☐

8. Do you have or have you had any of the following?

- ☐ Anemia
- ☐ Any Type of Cancer
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persisitent
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV /AIDS Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever History
- ☐ Scarlet Fever History
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tonsilitits
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other_____

	Yes	No
9. Are you allergic to or have you had any reactions to the following:		
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Codeine	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
10. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Patient Dental History

	Yes	No
• Do your gums bleed while brushing or flossing?	☐	☐
• Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
• Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
• Do you feel pain in any of your teeth?	☐	☐
• Do you have any sores or lumps in or near your mouth?	☐	☐
• Have you had any head, neck or jaw injuries?	☐	☐
• Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
• Does your mouth seem dry at times?	☐	☐
• Do you clench or grind your teeth?	☐	☐
• Do you bite your lips or cheeks frequently?	☐	☐
• Have you ever had any difficult extractions in the past?	☐	☐
• Have you ever had any prolonged bleeding following extractions?	☐	☐
• Have you had any orthodontic treatment?	☐	☐
• Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
• Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
• Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a monthly 1-1/2% finance charge (18% APR) will be added to my account. I further understand that I am responsible to pay reasonable attorney's fees and costs of collection in the event of default.

X _____ Signature of patient (or parent if minor) Date _____

HIPAA PRIVACY FORM 1

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. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

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.

NOTICE OF PRIVACY PRACTICES

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 YOUR 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 April 14, 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 HEALTH 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: 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 Patient 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 may 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, your 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 uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page, $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jennifer L., Miller

Telephone: (507)452-9453 Fax: (507)452-5420

E-mail: jmiller@riverhillsdental.com

Address: 720 HWY 61 E. Winona, MN 55987
