

# Patient Registration Forms

\*\*\*\*Please take a moment to completely fill out ALL forms.\*\*\*\*

## **PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: S M D CU W

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ FT PT

**Student Status** (IF OVER 18) College Name & Address required: FT PT

Name Of School: \_\_\_\_\_ Address: \_\_\_\_\_

## **In case of an emergency, whom would you like us to contact?**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

## **IF PATIENT IS A MINOR:**

Mothers Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fathers Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_ Work#: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## **INSURANCE INFORMATION**

### **DENTAL INSURANCE**

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

### **MEDICAL INSURANCE**

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\*\*\*\*\***IF YOU HAVE ADDITIONAL INSURANCE COVERAGE, PLEASE LET US KNOW.**\*\*\*\*\*

## **PLEASE READ THE FOLLOWING CAREFULLY.**

I authorize Jim L. Culver, DDS to furnish information to the policyholder's insurance companies concerning my treatment. I understand that all payments are due at the time of service, and in certain cases Dr. Culver will accept the assistance of certain insurances. However, when this office receives the insurance claim payment and there is a remainder amount that is still owed, I understand that I am personally responsible for ANY remaining amount. By signing this agreement I understand that I am personally responsible for the account balance due to Dr. Jim L. Culver and will be responsible for any and all additional fees to which will be applied in the event of a late payment, Stop Payment or NSF checks received. In the event a Stop Payment/NSF check is received you will be responsible for ALL additional charges and will be due IMMEDIATELY. In the event your account is forwarded to a collection agency, small claims court, the police department, or forwarded to an attorney you will also be responsible for any additional fees from the third party collectors, reasonable attorney fees, and/or Small Claims processing fees any of these to include any combination will apply if necessary. Additional fees are as follows: Stop Payment/NSF check fee \$30.00, monthly interest charge (5% of balance) also administrative charges (40% of balance).

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to patient**

| Do you have, or have you had any of the following? Please check all that apply. | YES | NO |
|---------------------------------------------------------------------------------|-----|----|
| Are you allergic to any of the following:                                       |     |    |
| Latex or Rubber Products?                                                       |     |    |
| Penicillin or other antibiotics?                                                |     |    |
| Local Anesthetics?                                                              |     |    |
| Food products? (including eggs)                                                 |     |    |
| Any Medications? Please be Specific.                                            |     |    |
| Is premedication necessary? Please explain.                                     |     |    |
| Heart Murmur?                                                                   |     |    |
| Heart Disease?                                                                  |     |    |
| Cardiovascular Disease? (Heart trouble)                                         |     |    |
| Angina? (chest pain)                                                            |     |    |
| History of Heart Attacks? If yes, when?                                         |     |    |
| Heart Surgery? If yes, please explain surgery and when.                         |     |    |
| Do you have a Pacemaker?                                                        |     |    |
| History of Stroke? If yes, when?                                                |     |    |
| Scarlet or Rheumatic Fever?                                                     |     |    |
| High Blood Pressure?                                                            |     |    |
| Low Blood Pressure?                                                             |     |    |
| Asthma? If yes, do you use an inhaler?                                          |     |    |
| Bronchitis?                                                                     |     |    |
| Emphysema?                                                                      |     |    |
| Chronic Obstructive Pulmonary Disease? (COPD)                                   |     |    |
| Shortness of Breath?                                                            |     |    |
| Tuberculosis?                                                                   |     |    |
| Acid Reflux?                                                                    |     |    |

| Continued                                                                                                          | YES | NO |
|--------------------------------------------------------------------------------------------------------------------|-----|----|
| Nervous Disorder? Please explain.                                                                                  |     |    |
| Epilepsy?                                                                                                          |     |    |
| Seizures?                                                                                                          |     |    |
| Porphyria?                                                                                                         |     |    |
| Blood Disorders? Please explain.                                                                                   |     |    |
| Anemia?                                                                                                            |     |    |
| Kidney Disease?                                                                                                    |     |    |
| Liver Disease?                                                                                                     |     |    |
| Hepatitis?                                                                                                         |     |    |
| Diabetes?                                                                                                          |     |    |
| Thyroid Disease?                                                                                                   |     |    |
| Cancer/Malignancy?<br>Please explain and include if you have had surgery, radiation treatment and/or chemotherapy. |     |    |
| Bone Disease?                                                                                                      |     |    |
| Arthritis?                                                                                                         |     |    |
| Joint Replacements? If yes please explain surgery and when?                                                        |     |    |
| HIV and/or AIDS?                                                                                                   |     |    |
| Herpes? (oral or genital)                                                                                          |     |    |
| Are you pregnant or nursing?<br>If yes, how many months?                                                           |     |    |
| Do you smoke?<br>If yes, how much?                                                                                 |     |    |
| Are you currently using any recreational drugs?<br>Please list.                                                    |     |    |
| Do you wear contact lenses?                                                                                        |     |    |
| Are you wearing any oral or facial piercing?                                                                       |     |    |
| Do you currently have a cold?                                                                                      |     |    |

Do you have any conditions or disease that is not listed above and feel we should be aware of? If yes, please explain? \_\_\_\_\_

Please list all medications **(including dosage amount)** you are taking now: \_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Please note: It is especially important to tell us if you are taking Biophosphinates, Tranquilizers, Dilantin, Phenobarbital, Blood pressure and heart medications, Cortisone medicines, Insulin, or any medicine to prevent blood clots.**

Please describe your chief complaint for this visit: \_\_\_\_\_

Was this due to some type of an accident? ☐ YES ☐ NO If so please explain: \_\_\_\_\_

Who is your regular Physician? \_\_\_\_\_ Year of Last Physical/Check-up: \_\_\_\_\_

Who is your regular Dentist? \_\_\_\_\_ Do you have recent X-Rays? ☐ YES ☐ NO

Who referred you to Dr. Culver? \_\_\_\_\_ Have you been treated in our office before? ☐ YES ☐ NO If yes, when \_\_\_\_\_

Has anyone in your family ever been treated in our office? ☐ YES ☐ NO Please list their names: \_\_\_\_\_

INFORMATION REVIEWED BY: **Nurse:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

***Jim L. Culver, D.D.S***

Oral & Maxillofacial Surgery

417 US Route 302 – Berlin

Barre, Vermont 05641

Tele: 802-479-3243

Fax: 802-479-3244

***PATIENT DISCLOSURE INSTRUCTIONS***

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone \_\_\_\_\_

☐ Written Communication

☐ O.K. to leave message with detailed information

☐ O.K. to mail to my home address

☐ Leave message with call-back number only

☐ O.K. to mail to my work/office address

☐ O.K. to fax to number indicated

☐ Work Telephone \_\_\_\_\_

☐ Other (Fax/Cell, etc.) \_\_\_\_\_

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

I allow you to give my clinical information to or answer questions in reference to the treatment to be or that has been provided to (*check all that apply*):

☐ Spouse

☐ Parent

☐ Child

☐ Other (specify): \_\_\_\_\_

☐ None

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth date

**Jim L. Culver, DDS**  
**Oral & Maxillofacial Surgery**  
417 US Route 302 – Berlin  
Barre, Vermont 05641  
Tele: 802-479-3243

**Consent For Use and Disclosure of Health Information**  
**\*\*You are entitled to a copy of this Consent after you sign it. \*\***

Patient Name: \_\_\_\_\_

Parent/ Legal Guardian's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

**To the patient – Please read the following statement carefully:**

**Purpose of Consent:** By signing this form, you hereby give your consent for our use and disclosure of the above named persons protected health information to carry out treatment, payment activities and healthcare operations, as outlined in our Notice of Privacy Practices. By signing below you also acknowledge that you have received and read a copy of our office's Notice of Privacy Practices. A copy of our Notice accompanies this Consent.

We encourage you to review it carefully and completely before signing this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of the other important matters about your protected health information affiliated with this office. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Attn: HIPAA Security Officer  
417 US Route 302 – Berlin  
Barre, Vermont 05641  
(T) 802-479-3243 (F): 802-479-3244

I, \_\_\_\_\_, have received a copy and was given full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my permission for this office's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I understand that my protected health information will not be given to any entity not associated with persons outlined in this office's Notice of Privacy Practices, including family members, unless I have requested it. All questions and concerns regarding this form and the Notice of Privacy Practices have fully been explained to me, and by signing below I hereby give my consent for use and disclosure of my protected health information to the office of Dr. Jim L. Culver.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative's/Guardians Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Revocation of Consent Forms Are Available to you at request.**

*Jim L. Culver, D.D.S*  
*Oral & Maxillofacial Surgery*  
*417 US Route 302 – Berlin*  
*Barre, VT 05641*

## ***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 as of 4/14/2003, 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 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. Revised Notices are available upon request, and are posted in our office for your review.

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 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 are entitled to use your health information or to disclose it to anyone for any purpose by written request. If you give us an authorization, you may revoke it in writing at anytime. 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. Your signed Consent For Use and Disclosure of Health Information does not permit to any circumstance not listed under the uses and disclosures of health information as outlined in this form. All written requests must be made specific as to who or what agency we are releasing your protected health information to.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We will only 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, and only if we have your permission to do so first.

**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 to 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.)

**Electronic mail:** We may obtain and/or disclose your protected health information via electronic mail for the purpose of payment, treatment and other healthcare operations. This practice does not encrypt our email.

## **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, there may be fee's associated with 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 your 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.

**Restrictions:** 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 emergency situations).

**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 reserve the right to deny your request under certain situations.

**Electronic Notice:** If you receive this Notice by electronic mail (email), 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 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: Jim L. Culver, D.D.S.  
Telephone: (802) 479-3243  
Fax: (802) 479-3244  
Address: 417 US Route 302 – Berlin  
Barre, Vermont 05641

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