

Patient Information

Patient Name: _____ Date: _____

Last, First, MI

/ (Preferred Name)

Gender: _____ Family Status for Insurance Purposes: (Primary/InsCarrier, Married, Single, Child, Other)

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____ (Other): _____

Primary personal email address: _____

Address: _____

Street

Apt #

City

State

Zip Code

Personal Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following conditions or medications? Please check those that apply:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Nervous Disorders | DRUG ALLERGIES: |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Grafts/Stents/Shunts | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy (currently) | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis | Date: _____ | Due date: _____ | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Artificial Joints _____ | <input type="checkbox"/> Heart Attack / MI | <input type="checkbox"/> Radiation Treatment | _____ |
| Date: _____ | Date: _____ | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease / Stent | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Bis-Phosphonates | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Current Medications |
| <input type="checkbox"/> Blood Dyscrasia/Ds. | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoke / Tobacco Use | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Infective Endocarditis | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Diabetes (Type I/II) | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke / TIA | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | Date: _____ | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tumors / Cancer | _____ |
| <input type="checkbox"/> Fainting | | <input type="checkbox"/> Ulcers | _____ |
| | | <input type="checkbox"/> Venereal Disease | _____ |

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health status or medical history, I will inform the doctor or hygienist at the next appointment without fail.

Date: _____

Signature of patient or parent / guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient (friend/relative) Internet/Web

Dental Office Phone Directory Newspaper School Work Other _____

Name the above specifically referring you to our practice: _____

Spouse/Responsible Party/Emergency Contact Information

The following is for: the patient's spouse/parent the person responsible for payment emergency contact

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ ext: _____ (Cell): _____
Primary personal email address: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City, State Zip Code _____ Phone _____

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: _____
Street _____ City _____ State _____ Zip Code _____
Insured's Employer Name: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from its patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Additionally, appointments must be respected and all appointments canceled without 24 hours notice are subject to a \$50.00 late cancellation charge.

All emergency dental services or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. It is the insured's responsibility to understand his/her dental benefits and is responsible for all charges incurred, not covered by insurance.

Please note that x-rays are a necessary part of providing you with comprehensive dental care. If recent prior x-rays are not brought to your appointment, legally new x-rays will have to be taken. Please note that many insurance companies have limitations on the number of panoramic, bitewings and full-series taken within a period of time. Therefore, if the x-rays taken at your dental visit are not covered by your insurance, you will be financially responsible for those charges. Once you are a continuing patient of Sunnybrook Dental, any x-rays not covered due to these limitations will be the responsibility of this office and will not be charged to your account. **Many insurance providers render benefits based on the least expensive alternative treatment philosophy they self-create.** For example, some benefits will only be paid for a silver / amalgam filling even though you have been provided with a composite / tooth colored filling. Please note this and duly recognize there may be a cost difference.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

Duly signed: In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content. I also fully understand and agree to the HIPPA disclosure and protection agreement.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____

HIPPA AGREEMENT

**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.**

This Notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Use and Disclosures of Protected Health Information: Your protected health information 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. **Payment:** Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. **Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, we may use or disclose your protected health information, as necessary, to contact you of your appointment. We may use or disclose your protected health information in the following situations with out your authorization. These situations include: as Required By Law; Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: legal proceedings: law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of section 164.500. **Other Permitted and required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.** **You may revoke this authorization**, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights: Following is a statement of your rights with the respect to your protected health information. **You have the right to Inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. **You have the right to request a restriction of your protected health information.** This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. *You* may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health care Professional. **You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively i.e. electronically. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. Complaints: You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.** This notice was published and becomes effective on/or before April 23, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by the phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature: _____ Date: _____

Print Name: _____