REGISTRATION FORM

Name(last)_____(first)_____(middle initial)____
Preferred Name_____ Sex____ Social Security Number_____
Single____ Married____ Widowed____ Divorced____ **Birthdate** _____
Address_____
City_____ State_____ Zip Code_____
Telephone(home)_____ Cell _____Work_____
E-mail Address_____
Occupation_____ Employer_____
Employer's Address_____
If Self Employed, Name of Business/Address_____
Whom Can We Thank For Referring You_____
General Dentist_____ Frequency of Dental Cleanings_____
Date of Last Cleaning_____
Hobbies/Intrests_____
Spouse's Name_____
Person to Notify in an Emergency(if different from home)_____
Telephone Number_____

DENTAL INSURANCE INFORMATION

Subscriber's Name_____
Subscriber's Employer_____
Subscriber's Social Security #_____ Subscriber's date of birth_____
Insurance Co. Name_____ Group Number_____
Identification Number if Different from Social Security#_____
Insurance Co. Telephone Number_____
Insurance Co. Address_____
Secondary Insurance Name & Address_____
Subscriber's Name_____ Subscriber's Social Security #_____
Group Number_____ Telephone Number_____

I agree to be responsible for all charges for dental services and material not paid by my dental benefit plan. To the extent permitted by law, I authorize release of any information relating to this claim.

Signature_____Date_____

I authorize Dr. Gerald Green to utilize my photographs/images/models for instructional and educational purposes.

Signature_____Date_____

I hereby authorize payment of dental benefits directly to Dr. Gerald Green.

Signature_____Date_____

Health Questionnaire

The health of your body and certain health conditions or medications can have significant interactions with the treatment you receive. Please answer the following questions as accurately as possible. Thank you.

Name: _____ Date: _____ Date of Birth: ___/___/___

HEALTH HISTORY

Are you under the care of a medical doctor? ___Yes ___No (If yes please explain below)

_____

Please provide your doctor's name and telephone number: _____

Date of your last physical exam (approximately): _____

Have you been hospitalized in the last two years? ___Yes ___No (If yes please explain below)

_____

Are you taking medications or herbal supplements? ___Yes ___No (If yes please list **ALL**)

_____

_____

Do you take aspirin on a daily basis? ___Yes ___No If yes, how many mg _____

Do you Pre-medicate with antibiotics prior to your dental appointments for artificial joints or a heart condition? ___Yes __No (If yes, please list the reason why & which antibiotic you take)

_____

Have you ever had an allergic reaction to any medication, anesthetic or latex? ___Yes ___No
If yes, please list medications/reaction_____

Have you ever taken bone density/osteoporosis (bisphosphonates) medications? ___Yes ___No
If yes, what medication, when and for how long? _____

Do you smoke or chew tobacco products? ___Yes ___No If yes, how much _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Please check **any** that apply:

☐ AIDS	☐ Excessive bleeding	☐ Mitral valve problems
☐ Alzheimer	☐ Eye disease/glaucoma	☐ Organ transplant
☐ Anemia	☐ Fainting/dizziness	☐ Psychiatric care
☐ Angina	☐ Frequent headaches	☐ Radiation treatments
☐ Artificial joints	☐ Heart attack/failure	☐ Rheumatism/arthritis
☐ Asthma	☐ Heart murmur	☐ Shingles
☐ Blood disease	☐ Heart disease	☐ Sickle cell disease
☐ Breathing problems	☐ Heart valve replacement	☐ Stomach disease
☐ Cancer	☐ Hepatitis Type ___	☐ Stroke
☐ Chemotherapy	☐ High blood pressure	☐ Thryoid disease
☐ Convulsions	☐ Irregular heart beat	☐ Tuberculosis
☐ Diabetes TYPE ___	☐ Kidney problems	☐ Tumors/growths
☐ Drug addiction	☐ Leukemia	☐ Ulcers
☐ Emphysema	☐ Liver disease	☐ Venereal disease(STD)
☐ Epilepsy/Seizures	☐ Lung disease	

Do you have any condition/ disease that is not listed above: ___Yes ___No
If yes, please explain: _____

Health Questionnaire

WOMEN:
Are you pregnant? ___Yes ___No How many months: _____ Breastfeeding: ___Yes ___No
Are you taking birth control pills? ___Yes ___No

DENTAL HISTORY
What dental concerns do you have? _____

Have you ever had problems, or anxiety with previous dental care? ___Yes ___No
If yes, please explain: _____

Who is your dentist? _____
Name Phone #

Date of last dental cleaning (approximately): _____

Frequency of dental cleanings: _____ times a year

Oral hygiene aids used at home: _____

Type of toothbrush ___soft ___hard ___Manual ___Electric
How often do you brush? _____

Do you floss? ___Yes ___No If yes, how often _____

Do you notice bleeding when you brush or floss? ___Yes ___No

Have you previously been treated for Periodontal (gum) disease? ___Yes ___No
If yes, what treatment and when:
_____
_____

I have completed the medical history and the answers given are true to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to notify our office of any changes in the above medical status.

Signature: _____ Date: _____

MEDICAL HISTORY UPDATED

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 1, 2004, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer	Aurora Green
Office Name	Gerald C. Green, D.M.D.
Address	2207 Oregon Pike Suite 201
City, State, Zip	Lancaster, PA 17601
Phone	(717) 299-5544

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Gerald C. Green, D.M.D.
2207 Oregon Pike Suite 201
Lancaster, PA 17601
(717) 299- 5544

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other