CAMBRIDGE DENTAL CENTER – PATIENT REGISTRATION

Date ____________________

______________________ ______________________ ______ ______________ _____
Patient's Last Name First Name MI Birthdate Age

Soc. Sec. No.: ____________________ Home Phone: ______________ Work Phone: ______________

Home Address: ____________________ City ______________ State ________ Zip ____________

Your Employer: ______________________________ Occupation: ______________

Employer's Address: ____________________ City ______________ State ________ Zip ____________

If student, name of School/College: ____________________ Cell Phone: ______________

Spouse's Name: ____________________ Birthdate ______________ Age __________

Soc. Sec. No.: ____________________ Home Phone: ______________ Work Phone: ______________

Employer: ______________________________ Occupation: ______________

Employer's Address: ____________________ City ______________ State ________ Zip ____________

Physician: ____________________ City: ______________ Date of last physical: ______________

Former Dentist: ____________________ City: ______________ Date of Last Visit: ________ X-Rays: ________

Nearest Relative **NOT** living with you: Name: ______________________________ Phone: ______________

Address: ____

Whom may we thank for referring you to us? ______________________________

Who is financially responsible for this bill? ______________________________

Is this person currently a patient in our office? ☐ Yes ☐ No

DENTAL INSURANCE INFORMATION

Insured Person's Name: ______________________________ Ins. Company ______________

Group #: ____________________ Local #: ____________________

Does your dental insurance cover: Self only or Family

Does your spouse have other dental insurance? ______________________ *(If yes, please give us the following:)*

Ins. Company: ______________ Group #: ______________ Local #: ______________

Does your spouse's dental insurance cover: Self only or Family

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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 child 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 the services are rendered, unless other payment arrangements were made prior to the treatment. For any account over 60 days a 12% annual finance charge will be applied. I agree to pay any costs spent to collect any amounts owed. This can include costs for hiring a collection agency, court costs and reasonable attorney's fees.

I will notify you of any changes in my health status or the above information. I understand that if I fail to give adequate cancellation notice (24 hrs.) of an appointment there may be a $50.00 reappointment fee charged.

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full may be required at each appointment.

☐ Cash ☐ Personal Check Credit Card: ☐ VISA ☐ Discover ☐ MasterCard ☐ I wish to discuss the office's payment policy.

We offer a 5% discount for payment in full on appointment day.

X ____
Signature of patient (or parent if minor)

CONTINUED ON BACK OF PAGE

Patient Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
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 Phen-Fen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐
8. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐
9. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you taking oral contraceptives?	☐	☐

Continued above

10. Do you have or have you had any of the following?	Yes	No
Joint Replacement or Implant	☐	☐
Heart Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Angina	☐	☐
Cardiac Pacemaker	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
Liver Disease / Jaundice	☐	☐
Lupus	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting / Seizures	☐	☐
Asthma	☐	☐
Epilepsy / Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problem	☐	☐
Organ Transplant	☐	☐
Anemia	☐	☐
Emphysema	☐	☐
Cancer	☐	☐
Type ______________		
Arthritis	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Sinus Trouble	☐	☐
Stroke	☐	☐
Hay Fever / Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Respiratory Problems	☐	☐
Low Blood Pressure	☐	☐
Other	☐	☐

Patient Dental History

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive or painful?	☐	☐
3. Do you have any sores or lumps in or near your mouth?	☐	☐
4. Have you had any head, neck or jaw injuries?	☐	☐
5. 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	☐	☐

	Yes	No
6. Do you have frequent headaches?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Have you ever had difficulty with extractions in the past?	☐	☐
9. Have you ever had any prolonged bleeding following extractions?	☐	☐
10. Have you had any orthodontic treatment?	☐	☐
11. Do you wear dentures or partials?	☐	☐
If yes, year of placement ______________		
12. Do you have an exceptionally dry mouth?	☐	☐
13. Do you like your smile?	☐	☐

Medical Update

Date	*Initial*	*Date*	*Initial*	*Date*	*Initial*

Cambridge Dental Center

Matthew J. Peterson, D.D.S., P.A.

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 (09/22/2002), 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: Nancy F.

Telephone #: 763-689-1554

Fax#: 763-552-1473

Address: 124 E. First Ave., Cambridge MN 55008

Cambridge Dental Center

Matthew J. Peterson, D.D.S., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign 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 other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Nancy F. Telephone #: 763-689-1554 Fax#: 763-552-1473

Address: 124 E First Ave, Cambridge MN 55008

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.

SIGNATURE

I, ________________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ________________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ________________________________

Relationship to Patient: ________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ________________________________ Date: ____________________