

DENTAL REGISTRATION AND HISTORY

| PATIENT INFORMATION | DENTAL INSURANCE |
|--|--|
| Date _____ | Who is responsible for this account? _____ |
| SS# _____ | Relationship to Patient _____ |
| Patient Name _____ Last Name | Insurance Co. _____ |
| _____ | Group# _____ ID # _____ |
| First Name Middle Initial | Is patient covered by additional insurance Yes No |
| Address _____ | Subscriber's Name _____ |
| E-mail _____ | Birthdate _____ SSN _____ |
| City _____ | Relationship to Patient _____ |
| State _____ Zip _____ | Insurance Co. _____ |
| Sex M F Age _____ | Group # _____ |
| Birthdate _____ | Assignment And Release |
| Circle One : Married Widowed Single Minor | I certify that I, and/or my dependent(s) have insurance coverage with |
| Separated Divorced Partnered for _____ yrs | _____ and assign directly to |
| Patient Employer/School _____ | Name of Insurance Company |
| Occupation _____ | Dr. _____ all insurance benefits, if any, |
| Employer/School Address _____ | Otherwise payable to me for services rendered. I understand that I am |
| _____ | financially responsible for all charges whether or not paid by insurance. |
| Employer/School Phone(____) _____ | I authorize the use of my signature on all submissions. |
| Spouse's Name _____ | The above-named dentist may use my health care information and may |
| Birthdate _____ | disclose such information to the above-named Insurance Company(ies) and |
| SS# _____ | Their agents for the purpose of obtaining payment for services and |
| Spouse's Employer _____ | determining insurance benefits or the benefits payable for related services. |
| Whom may we thank for referring you? _____ | This consent will end when my current treatment plan is completed or one |
| | year fro the date signed below. |
| | _____ Signature of Patient, Parent, Guardian or Personal Representative |
| | _____ Please print name of Patient, Parent, Guardian or Personal Representative |
| | _____ Date Relationship to Patient |

| PHONE NUMBERS |
|---|
| Home() _____ Work () _____ Cell Phone () _____ Best time to reach you _____ |
| Spouse's Work _____ Cell Phone () _____ |
| In Case Emergency, Contact (Specify someone who doesn't live with you – contact will also be used when unable to reach you) |
| Name _____ Relationship _____ |
| Home Phone () _____ Work () _____ |

MEDICAL HISTORY

FOR
3608--1a 1a
Birth Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No | | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

 SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

RIVERSIDE DENTAL^{PC} PATIENT RECORD OF DISCLOSURES

In general, the HIPPA 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 or the individual's home

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

Home Telephone _____

- O.K to leave message with detailed information
- Leave message with call-back number only

Written Communication

- O.K to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number

Work Telephone _____

- O.K to leave message with detailed information
- Leave message with call-back number only

Other _____

Patient Signature

Date

Patient Signature

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures; information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

| Date | Disclosed to Whom Address or Fax Number | (1) | Description of Disclosure/ Purpose of Disclosure | By Whom Disclosed | (2) | (3) |
|------|--|-----|---|-------------------|-----|-----|
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(1) Check this box if the disclosure is authorized
 (2) Type Key: T=Treatment Records P=Payment Information O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

RIVERSIDE DENTAL^{PC}

OFFICE FINANCIAL POLICY

Many people are under the impression that if they have insurance, it is the insurance company who owes the doctor for his services. The insurance contract is between the patient and the insurance company; therefore, the patient is ultimately responsible for the bill, regardless of the insurance coverage determination. As a courtesy to our patients, we are happy to bill your primary insurance for you, **however the responsibility for payment remains with the patient or guardian.** If you have additional questions regarding our services or your insurance please ask prior to treatment being performed.

1. **PATIENTS WITH INSURANCE:** **At the time services are rendered, patients are requested to make an initial payment toward the estimated charges.** Most services require a co-payment of “20%,50%, or 80%” based upon their employers contract with the dental insurance company. Although we are given an estimate as to what they will pay it depends upon review of the claim as to the actual benefits that will be paid. Most insurance companies pay on the least expensive acceptable material thus if one wanted composite fillings they may only pay their portion of the lesser amalgam fee. In this case the patient will be responsible for the difference. In some cases although it is shown as a covered benefit the insurance company may not pay for certain procedures thus the patient is responsible.
2. **DEDUCTIBLES:** Most insurance plans have a \$25-100 single deductible and \$50-250 family deductible. This must be paid to our office up front because the insurance will deduct it from the claim check when services are rendered. The deductible usually applies to all fillings, crowns, emergency visits, and periodontal cleanings but not usually to preventive services, however some patients may have one if part of the plan they selected. Ie: low vs high option.
3. **PATIENTS WITHOUT INSURANCE:** Patients without insurance are required to **pay the charges in full at the time services are rendered.**
4. **ACCOUNT BALANCES:** The balance on all accounts is due in full within 90 days regardless of insurance coverage or anticipated payment from other sources. **In the event that payment for our services is not made within 90 days of receipt of services, an interest charge of 1.5% per month will be added to the account (18% per year), or \$5.00, whichever is greater.** Therefore, patients with insurance whose claims have not been paid within 45 days should contact their insurance company to determine the reason for delay of payment.

Delinquent accounts will be referred for collection at the discretion of the doctor, and a **\$100.00 charge will be assessed for all accounts sent to collections.**

5. **CANCELLATION POLICY:** Dental appointments cancelled without 24 hours notice or a “no show” will be subject to a \$25 cancellation charge. If the appointment is for longer than an hour then the fee will be based on \$25 per hour allotted for that procedure. We will give you a call 48 hrs in advance to remind you of your appointment and we ask that if a message is left you call back to confirm you received the message. Please make sure if you move to give us your updated phone number and address so we can contact you.

6. **DUPLICATION AND TRANSFER OF RECORDS:** When you get x-rays you are paying for the diagnosis of the x-rays and not the x-rays themselves. All original x-rays must remain in our office. If you are moving out of state or transferring to another office **your x-rays and records may be obtained for a \$20 duplication fee per individual.** A release form must be signed by the patient or guardian in our office. In the event an x-ray duplicate is needed for a specialist one will be available free of charge for the patient to take for the consultation.

7. **PAYMENT OPTIONS:** Personal checks, cash, money order, or visa/ Discover/ MasterCard/ American Express may be used for payment on your account. We have two different financing plans available if qualified that have many different payment options available and some with “zero” interest depending on the amount of treatment. If you are interested in one of these please ask the front office for details.

ASSIGNMENT AND RELEASE: For individuals with insurance, your signature below hereby authorizes your insurance benefits to be paid directly to Riverside Dental, PC. It also authorizes the doctor to release any information required for payment and processing of a claim. Please sign below to acknowledge your understanding of our office financial policy.

Signature of Patient, Parent, or Guradian

Date

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 (MM/DD/YR), 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 \$25.00 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: Dr. Jason Kirkland

Telephone: 520-299-4470

Fax: 520-299-4475

Address: 1640 E. River Rd. Suite #112 Tucson, AZ 85718



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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