Patient Information

Patient Name: _____ Birth Date: _____ Male/Female
Last First MI

__Married __Single __Child Social Security#_____

Address: _____ Apt#_____

_____ _____ _____
City State Zip

How did you hear about our office? _____

Responsible Party Information

The following is for the person responsible for payment: __self __spouse __parent/guardian

Patient Name: _____

Birth Date: ___-___-_____ Social Security #: _____-____-_____
mo day year

Phone (Home): _____(work):_____(Cell): _____

E-mail: _____ Fax: _____

Address: _____ Apt#_____

_____ _____ _____
City State Zip

Insurance/Dental Plan Information

Primary Plan Name: _____ Group#: _____Member ID: _____

Insurance Address: _____

Insurance Phone #: _____

Employer: _____

Policy Holder's Name: _____

Social Security #: _____ Birth Date: _____

Secondary Plan Name if applicable:_____ Group#: _____Member ID: _____

Insurance Address: _____

Insurance Phone #: _____

Employer: _____

Policy Holder's Name: _____ SS#: _____ Birth Date: _____

Health Information

Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for Today's Visit: _____

Have you ever had any of the following? Please check all that apply:

__AIDS/HIV+
__Allergies:
_____
_____
__Anemia
__Arthritis
__Artificial Joints
__Artificial/Leaky Heart Valve
__Asthma
__Blood Disease
__Bruise Easily
__Cancer
__Cold Sores/Fever Blisters
__Contact Lenses
__Cortisone med.
__Restricted Diet
__Dizziness
__Emphysema
__Epilepsy
__Excess Bleeding
__Fainting
__Glaucoma
__Growth
__Hay Fever
__Head Injuries
__Heart Attack/ Disease/ Surgery
__Heart Murmur
__Hemophilia
__Hepatitis
__High BloodPressure
__Diabetes
__Kidney Disease
__Latex Sensitivity
__Liver Disease
__Mental Disorders
__Mitral Valve Prolapse
__Nervous Disorders
__Pacemaker
__Psychiatric/ Psychological Care
__Pregnancy: ___wks
__Radiation Treatment
__Respiratory Problem
__Rheumatic Fever
__Rheumatism
__Sinus Problems
__Smoking/Chewing
__Jaundice
__Stomach Problems
__Stroke
__Thyroid Problems
__Tuberculosis
__Tumors
__Ulcers
__Codeine Allergy
__Penicillin Allergy
__Aspirin Allergy
__Allergic/Adverse Reaction to Med or Any Substance: ___
_____
__Pre-medication w/ antibiotics prior to dental visits

*Have you ever taken any of the following osteoporosis medications: Zometa, Aredia, Fosamax or Actonel? __Yes __No If yes, please list. _____

*Have you ever had any complications following dental treatment? __Yes __No If yes, please explain.

_____

* Have you ever 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.

_____

*Are you taking any medications? Purpose? Please list. _____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without failure.

_____ Date: _____

Signature of patient, parent or guardian

Buckland Hills Dental

QUALITY DENTAL CARE FOR KIDS & ADULTS

HIPAA information and consent

The health insurance portability act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complex text is posted in the office.

What is this all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care Additional information is available from the U.S Department of Health and Human Services www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as if necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily; in the administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records .PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy and new technology that you might find valuable or informative.

3. The Practice utilizes a number of vendors in the conduct of business. These Vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.

6. Your confidential information will not be used for purposes of marketing or advertising of product goods or services.

7. We agree to provide patients with access to their records in accordance with the state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the need of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in the certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request

I,_____ Date:_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in the office policy. I understand that this consent shall remain in force from this time forward.

Buckland Hills Dental

QUALITY DENTAL CARE FOR KIDS & ADULTS

Appointment Cancellation Policy

Dear Patient,

The office would like to inform all Patients/Parents that our office will charge a fee of $50.00 for all broken appointments; regardless if our receptionist gave you a reminder call the day before the appointment.

Our office provides a reminder call as a courtesy. Therefore, if you do not call back to confirm, we assume that you will be in for your appointment. You will be charged $50.00 if you miss your appointment.

If you are unable to make your appointment we ask that you provide the office with at least 24 hours' notice to avoid being charged an appointment absence fee.

I, _____, have read and understand the above policy. **If for any reason I miss or cancel the appointment without 24 hour notice I will be charged a $50.00 fee.**

Printed Name:_____Date:_____

Signature:_____