Patient Information

Patient Name: ____ Date*:* ___________
Last, First MI (Preferred Name)

Gender: _____ Family Status: ______________ *Parent Name (if patient is a minor)*_____________________

Birth Date: ______________________________ Email Address: ______________________

Phone (Home): ________________ (Work): ________________ Ext: _________ (Cell): ______________________

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

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

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Thyroid problems
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Allergies:

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex

OTHER:
____
____
____
____

- Have you had any operation, serious illness, or been hospitalized in the last 2 years? Yes No
  If yes, please explain: ____
- Has there been any change in your general health in the past year? Yes No
  If yes, please explain:____
- Are you now under the care of a physician for any illness or health problem? Yes No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: _________________
- Do you Smoke? Yes No
- Do you have damaged heart valves or artificial heart valves? Yes No
- Do you have any health problems that need further clarification? Yes No
  If yes, please explain: ____

- Have you had any serious trouble associated with previous dental treatment? Yes No
  If yes, please explain:____
- Have you ever had a reaction to local anesthetic? Yes No
- Are you wearing any removable dental appliances? Yes No
- When was your last dental exam? ____
- What is your chief dental complaint? ____

Please list all medications you are currently taking (include dosage and frequency) ___________

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To the best of my knowledge, all of the preceding answers and information provided are true and correct. I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. If I ever have any change in my health, I will inform the doctors at the next appointment.

____ Date: ______________

Signature of patient, parent or guardian

Dental Insurance Information

Primary

Name of Insured: ____________________________________
Last First MI

Insured's Birth Date: _______________ SSN# or Subscriber ID# ____________________

Insured's Address (if different from patient) ______________________________________
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 Co. Name and Address: ____________________Group #:__________

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Consent for Payment of Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

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

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.**

I 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.

I have read the above conditions of treatment and payment and Notice of Privacy Practices and agree to their content.
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.

________________________________ Date: __________ Relationship to Patient: ______________

Signature of patient, parent or guardian

________________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

Dental Insurance

Dental Insurance Plans are different than Medical Insurance Plans.

Dental Plans: Yearly Maximum per person
Yearly Deductible per person
Pay percentages of allowable fees
(not necessarily the fees charged)

The type of plan *you* choose or your *employer* has chosen for you, determines the type of coverage you have.

Types of plans are: PPO – you are able to go to a dentist of your choice.
In-Network/ Out-of- Network – the option to choose a dentist of your choice, or from a list of providers
HMO – Network Providers only

To be a Network Provider the Dentist must agree to the contracted fees set by the insurance company.

Dr. Peterson has made every effort to establish fair and reasonable fees for the quality dental care you receive in our office.

Our office is not a network provider for all insurance companies. We are providers for Delta Dental Premier and PPO only.

Our office verifies your eligibility and insurance coverage, and estimates your out of pocket expense based on the percentages your company gives us. We are told when we contact all companies that this is an estimate only and not a guarantee of payment. **When we file your claim and your insurance does not pay what we have estimated, you are responsible for the difference.** Our office makes every effort to help you maximize the coverage you have. We cannot control what your insurance company allows or chooses to pay.

I have read and understand my responsibilities regarding my insurance.

Signed patient/insured________________________________**Date**________

Guy Peterson, DDS

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

Date: __________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

______________________________ ___________________________________
Please print name of Patient Signature of Patient, or Parent/Guardian

__________________________ _______________________________
If Parent/Guardian, please print your name Relationship of Parent/Guardian

Please list any other parties who can have access to your health information: (This includes spouse, step parents, grandparents and any care takers who can have access to this patient's records):

Name: _______________________ Relationship: ______________________________

Name: _______________________ Relationship: ______________________________ -

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Please choose the options in which our office may contact you:

Text message yes no
Email yes no
Mobile phone yes no
Home phone yes no
Work phone yes no

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, 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 HIPAA, 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 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 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, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. 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. 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 can 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.

The right to request an amendment to your protected health information.

The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

The right to obtain a paper copy of this notice from us upon request.

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 April 15, 2003 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 HIPAA or to file a complaint, please contact:
The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
877.696.6775 (toll-free)

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