PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Pharmacy #

Physician`s #

EMERG. PH. #

CELL PH. #

DENTAL I Q

Medical Record #

Physician"s Name

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

NOTICE OF PRIVACY PRACTICES

This Notice describes how we protect your health information and what rights you have regarding it. We are legally obligated to give you notice of our privacy practices, and moreover, keep health information that identifies you private.

THE 3 MOST COMMON REASONS WHY WE USE/DISCLOSE YOUR HEALTH INFORMATION:

1) TREATMENT:

This includes: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us.

2) PAYMENT:

This includes: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney).

3) HEALTH CARE OPERATIONS: (administrative/managerial functions which allow us to run our office).

This includes: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER REASONS WHY WE WOULD USE / DISCLOSURE YOUR HEALTH INFORMATION:

- when state or federal law mandates health information be reported for a specific purpose;
- for purposes of public health: (contagious disease reporting, investigation/surveillance; notice to/from FDA regarding drugs or medical devices;
- disclosure of authorities for victims of suspected abuse, neglect or domestic violence;
- uses/disclosures for health oversight activities: (licensing of doctors; audits by Medicare or Medicaid; violations of health care laws)
- disclosures for administrative proceedings: (subpoenas or court orders of administrative agencies)
- disclosure to medical examiner: (determine cause of death; organizations for organ/tissue donations)

APPOINTMENT REMINDERS

For your convenience, Appointment Reminders & Confirmations can be made in one of three ways: text message, email, and or phone. Moreover, notifications of pending treatment, and post card reminders of semi-annual dental check ups may be mailed to your home to ensure quality service.

REQUEST FOR PATIENT CHART / RECORDS

If a patient requests to review or to have a copy of their chart and or records, we have within 30 days (or sixty days if the information is stored off-site) to do so. A small fee will apply, which is due before receiving any records. In order to review or obtain records of your health information, please send a written request to our office.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

HIPAA AUTHORIZATION

I authorize Smile Perfector Dental Group to release health information identifying me [including if applicable, information about substance abuse treatment, mental health services, and HIV related information] under the following terms and conditions:

1) Description of the information to be released & to whom it may be released.
2) The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
3) Expiration date or event relating to the individual or purpose for the release:

I understand that signing this authorization is voluntary. Treatment cannot be refused to you if you choose not to sign this authorization.

I have the right to revoke this authorization at any time by writing to the health care provider listed, with the sole exception being that action has already been taken based on this authorization.

Information disclosed under this authorization might be redisclosed by the recipient.

Redisclosure may no longer be protected by federal or state law.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.