PATIENT REGISTRATION

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

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

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:

Advanced Dentistry Of Nevada, LLC.

Advanced Dentistry Medical History 4

Patient Name: 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, c

Are you under a physician's care now? What is their name?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for Osteoporosis?	Yes No	If yes
Do you use tobacco? How much per day? In what form: Vape, Cigarettes, Cigar, Pipe, or smokeless/dipping tobacco?	Yes No	If yes
Do you use controlled substances? If yes, what medications?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	

List All Medicine

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

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

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

Have you ever had any serious illness not listed above? Yes No If yes

Authorization and Release

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. 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 dental insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered, and agree to be responsible for payment of all services rendered on my behalf or my dependents.
I agree to give at least 48 business hours notice for cancellations or rescheduling appointments via phone call. If there is less than 24 hours notice from the start of my next appointment, I understand there will be a $50.00 per hour fee charged.

Signature of Patient, Parent or Guardian:

X Date:

ADVANCED
DENTISTRY OF
NEVADA, MO

Private Insurance Coverage Policy

For those who are covered by private insurance, we are pleased to extend the courtesy of billing your insurance company for you.

In order to provide this service for you, we must have complete insurance information and confirmation of your coverage. We ask that you complete all forms to provide us with the necessary information. Our office ***DOES NOT*** guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason the patient's insurance claim is denied, the patient is then responsible for the full amount of the bill. It is our policy that any procedure not covered by insurance or any out-of-pocket estimates are to be paid by the patient at the time of service.

If insurance company has not made payment **within 90 days of billing**, the balance will become the **responsibility of the patient**. Please remember that insurance is an agreement between the insured and the insurer. Therefore, if any problem arises with the carrier, we will ask that you address it with the insurance company. Our office will provide your insurance company with any additional information required for resolution.

Appointment & Financial Policy

At Advanced Dentistry of Nevada, we are committed to delivering quality and comprehensive dental care in a timely manner. When you schedule an appointment, we reserve that time just for you with our dental staff and doctor. We strive to see all patients on time for their scheduled appointment. We ask that you arrive 15 minutes prior to the appointment time. If you're unable to make your appointment, we request a 24-business hour (business hours are 7am-4pm Mon. – Thurs.) advanced notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $50.00 for missed appointments without proper notification as well as a chair side cancellation.

We accept cash, check, most major credit cards, Care Credit and Ally Financing. There is a $35.00 fee on all returned checks. Advanced Dentistry of Nevada, LLC reserves the right to change office policies at any time without notice.

I understand and agree to honor my financial commitment to the office of Advanced Dentistry of Nevada, MO as outlined above.

Patient Signature: _____Date: _____

ADVANCED DENTISTRY OF NEVADA, MO

Notice of Privacy Practice

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.

Advanced Dentistry of Nevada is committed to protecting your privacy and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Advanced Dentistry of Nevada and will tell you about the ways in which we may use rights and certain obligations we have regarding the use and disclosure of medical information with respect to your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time.)

We typically use or share your health information in the following ways:

- *Treat you*. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
- *Bill for your services.* We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
- *Run our office.* We can use and share your health information to run our practice, improve your care and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- *Help with Public Health and Safety Issues:* We can share health information for certain situations such as preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat of anyone's health or safety.
- *Comply with Law.* We can share information about you if state or federal law request, including the Department of Health and Human Services.
- *Do Research*. We can use and share information for health research.
- *Family and Friends.* We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative, or other person responsible for your care of your location, general condition, or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable sate law.
- *Organ and Tissue Donation request.* We can share information about you to organ procurement organizations.
- *Medical Examiner or funeral Director.* We can share information with a coroner, medical examiner, or funeral director when an individual dies.

Initials: _____

- *Worker Compensation, Law Enforcement Requests and Other Government Requests.* We can share health information for worker compensation claims, law enforcement purposes with health oversight agencies for activities allowed by law and other specialized government functions (e.g., military, and national security).
- *Lawsuits and Legal Actions.* We can share health information in response to court or administrative order or in response to a subpoena.

When it comes to your health information, you have certain rights, we typically use or share your health information in the following ways.

- *Get an Electronic or Paper Copy of your Medical information.* You have the right to inspect and/or obtain a copy of our medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) or your medical information, we may charge you a reasonable, cost-based fee.
- *Ask us to correct your Medical Record.* You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we will tell you why in writing within 60 days.
- *Confidential Communication.* You can ask us to contact you in a specific way (for instance, home or office phone) or send mail to different address for times such as appointment reminders. We will say yes to all reasonable requests.
- *Limits on what we use and share.* You can ask us NOT to share certain health information for treatment, payment and/or operations. We are not requested to agree to your request and if it affects your care, we may say no.
- *Accounting of Disclosures.* You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment and/or operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you as for another within 12 months.
- *Privacy Notice.* You can ask and receive a paper copy of this notice at any time.
- *Complaint.* You can file a complaint in you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., SW Room 509F HHH Bldg., Washington, DC, 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases, we will never share your information unless given written permission: Marketing Purposes, Fundraising, and the Sale of Information.

We may also create and distribute de-identified health information by removing all references in individually identifiable information.

We may, without prior consent, use or disclose protected heath information to carry out treatment, payment or healthcare operations in the following circumstances:

- If we are required by law to treat you and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent buy are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgement, your consent to receive treatment is clearly inferred from the circumstances.

Initials _____

Medical Information Release Form
(HIPAA Release Form)

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice or Privacy Practices. We will not share your information other than described in here unless we receive written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be release to:

- □ Spouse _____
- □ Children _____
- □ Other _____
- □ Information is not to be released to anyone

This Release of information will remain in effect until terminated by me in writing.

Message

Please Call: □ My phone □ My Work □ My Cell Phone

If unable to reach me:

- □ You may leave a detailed message
- □ Please leave a message asking me to return your call
- □ Other: _____

The best time to reach me is (Daytime) _____Between (time)_____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____