Family Dentistry

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security # _____

Sex: Male or Female Marital Status: Married or Single

Employer: _____ Phone Number: _____

PARENT OR GUARDIAN INFORMATION:

Name: _____ Relationship to the Patient: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Social Security #_____ Employer: _____ Phone Number: _____

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____ Social Security #_____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other

Insurance Co/Employer: _____

SECONDARY INSURANCE INFORMATION:

Name of Insured: _____ Social Security #_____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other

Insurance Co/Employer: _____

MEDICAL HISTORY

Are you under a physician's care now?	Yes or No	If Yes, please explain: _____
Have you even been hospitalized/had a major operation?	Yes or No	If Yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes or No	If Yes, please explain: _____
Do you take, or have you taken Phen-Fen or Redux?	Yes or No	If Yes, please explain: _____
Do you use tobacco?	Yes or No	If Yes, what type: _____
Do you use controlled substances?	Yes or No	

WOMEN:

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
- ☐ Acryllic
- ☐ Metal
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Sulfa
- ☐ Other: If Yes, Please Explain: _____
  _____
  _____
  _____

DO YOU HAVE, OR HAVE HAD, ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer/Chemotherapy
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis: A B C
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ None of the above

Do you take **Fosamax** or any other **osteoporosis medications**? Yes or No

Have you ever had any serious illness not listed? If Yes, please explain: _____

_____

List all medications, pills, or drugs you currently take, including any pain medications: _____

_____

I authorize the following persons' access to my health information:

Name	**Date of Birth**	**Home Phone Number**
_____	_____	_____
_____	_____	_____

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Guardian: _____ Date: _____

Family Dentistry

WRITTEN FINANCIAL POLICY

Thank you for choosing Minigh Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
    - Allows you to pay over time
    - No annual fees or pre-payment penalties

Please note:

We **require payment the day services are rendered**. If you have dental insurance we will call to verify eligibility and coverage prior to treatment. Coverage information obtained will be used to estimate your co-pay/deductible amount for services and will be collected at the time of treatment. If your treatment requires more than one appointment you have the option to pay your portion in two payments. The balance must be paid in full prior to the completion of your treatment. **We no longer render any office credit regardless of previous arrangements**. This excludes any existing written agreements that are not in default. Default accounts are those that have missed 2 or more payments. If you have any concerns prior to treatment and would like an estimate, please do not hesitate to speak with a staff member. This is in an effort to insure that you are informed of your financial responsibility prior to the beginning of treatment. If you choose to discontinue care before treatment is complete you will receive a refund less the cost of care that you have already received. It is your responsibility to request a refund check. If a request is not received, the credit balance will remain on the account ledger to be put toward future services.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment[2].

A fee of $25.00 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Dr. Minigh charges $25.00 for all returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and/or need.

Patient or Guardian: _____ Date: _____

Patient Name (please print): _____

[1] Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

NOTICE OF INFORMATION PRACTICES AND PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATON ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

Family Dentistry is required by law to maintain the privacy of "protected health information" or PHI. This information includes any identifiable information we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your healthcare. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to your PHI. You can always request a copy of the most current privacy notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Family Dentistry and its employees collect data about you that is either required by law, or necessary to process requests and claims. Information about your medical conditions and care that you provide to us in writing, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, sell, lend, or disseminate any information about patients who receive our services that is considered confidential, is restricted by law, or has been specifically restricted by a patient in a signed HIPAA consent form. Information is only used as is reasonably necessary to provide you with health services which may require communication between Family Dentistry and health care providers.

These uses or disclosures may include, but are not limited to, the following categories:

Treatment – We may use PHI provided to us to inform you of approaching events related to your healthcare.
Payment – We may use PHI provided to us to inform you of issues related to payment for your healthcare.
Healthcare operations – We may use PHI provided to us to assist your Covered Entity in serving you better.
Required by Law – We may use/disclose PHI when required to do so by law.
Abuse/Neglect – We may use/disclose PHI to appropriate authorities if we believe you are a possible victim of abuse, neglect or domestic violence.

If you provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

PATIENT'S RIGHTS

You have a right to:

- Expect your PHI will be kept secure and used only for legitimate purposes
- Understand how your PHI may be used and disclosed by Family Dentistry
- Access this privacy notice that tells you how your PHI may be used or disclosed
- Ask questions about any health privacy issue and have those questions clearly and promptly answered
- Know who has seen your health information and for what purpose
- See and to keep a copy of all your health records (request must be in writing)
- Authorize, or refuse additional uses of your PHI, such as for marketing or research
- Request extra protections for your PHI you consider especially sensitive
- Request we communicate with you by alternative means

COMPLAINTS

If you believe your privacy rights have been violated, you should immediately contact our Office Manager. We will not take any action against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services.

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HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Family Dentistry has provided me their Notice of Privacy Practices and reserves the right to change the described notice. By signing below, I understand that Family Dentistry will not disclose any information regarding my personal health and treatment without my consent, except for such reasons as, required by law, administrative proceedings and medical billing.

____ ____________________________

Printed Name of Patient Date

____

Signature of Patient/Responsible Party (please indicate reason)