Quail Ridge Dental - 8/28/2024

Patient Name

First Name	Last Name

Patient Information

PATIENT INFORMATION

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Today's Date	Title	Middle Name

I prefer to be called:		Gender	Date of Birth
Social Security #	Mailing Address	City	State
Zip	Home Phone	Cell Phone	Work Phone
Email Address	Employer	Occupation	Marital Status:
Name of Spouse	Spouse Phone Number	Emergency Contact Name	
Emergency Contact Phone			

Send appointment reminders via:

Text Message	Email	Phone Call

Please tell us where you heard about us (check all that apply):

Saw our Office	Insurance Company	Our Website	Search Engine (Google, etc.)
Friend or Relative (name)		Other	

PERSON RESPONSIBLE FOR ACCOUNT

Parent/Guardian Name	Relationship to Patient:		Date of Birth
Social Security #	Mailing Address	City	State
ZIP Code:	Cell Phone	Home Phone	Work Phone
Employer		Occupation	

PAYMENT POLICY

Payment is required as services are rendered. We do not carry accounts. A service charge of 1.5% per month (with a minimum of $0.50) will be applied to any patient balance over 30 days past due. Checks that are returned due to "insufficient funds" will be subject to a $25.00 service charge.
We reserve the right to charge a fee of $50.00 for broken appointments or cancellations with less than 24 hours notice.

Signature

Date

Insurance Information

PRIMARY INSURANCE

Insured's Name	Insured's Date of Birth	Relation to Patient
Insured's Social Security #	Insured's ID #	Group #
Employer	Insurance Company Name	
Insurance Company's Address	City	State
Zip	Insurance Company Phone	

SECONDARY INSURANCE

Insured's Name	Insured's Date of Birth	Relation to Patient
Insured's Social Security #	Insured's ID #	Group #
Employer	Insurance Company Name	
Insurance Company's Address	City	State
ZIP Code	Insurance Company Phone	

AUTHORIZATION

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan(s) is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

I hereby authorize payment directly to Quail Ridge Dental of the insurance benefits otherwise payable to me.

Signature

Date

Dental History

DENTAL HISTORY

Previous Dentist	Phone	Last Dental Visit (m/y):	
Last Bitewing X-rays (mm/yy):		Last Full-Mouth X-Rays (mm/yy):	
Last Cleaning (m/y):			
Dental Hygiene			
How often do you visit a dentist?		Do you brush your teeth?	Do you floss?
Dental Concerns (Check all that apply)		Tooth pain	Grinding/clenching/jaw pain
Sensitivity to hot/cold	Sensitivity to sweets	Periodontal (gum) problems	
Have you ever had: (Check all that apply)		Orthodontic treatment	Oral surgery
Periodontal treatment	A bite plate or mouth guard	A serious injury to the mouth or head? If yes, please describe including cause:	

Medical Information

MEDICAL HISTORY

How is your general health?		Are you currently under medical treatment?	Do you require antibiotic pre-medication for your dental work?
Physician's Name	Phone	Last Visit mm/yy	Do we have permission to contact your doctor regarding your care?

Have you had or do you have? Check all that apply

A Fib	Acid Reflux	AIDS/HIV	Allergies/Hay Fever
Alzheimer's/Dementia	Anemia	Angina	Arthritis/Rheumatism
Asthma	Back Problems	Bladder problems	Blind
Blood Transfusions	Cancer	Chemical Dependency	Chemotherapy/Radiation
Chest Pain	Cholesterol	Congenital Heart Defect	COPD
Diabetes	Dizziness/Fainting	Emphysema	Epilepsy/Seizures
Excessive Bleeding	Fibromyalgia	Glaucoma	Heart Problems
Heart Surgery	Hepatitis	High Blood Pressure	Hypoglycemia
Joint Replacement	Kidney Disease	Liver Disease	Low Blood Pressure
Lupus	Mental Health problem	Migraines	Multiple Sclerosis
Muscular Dystrophy	MVP/Heart Murmur	Nervousness	Organ Transplant
Osteoporosis	Pacemaker	Parkinson's Disease	Persistant Cough

Respiratory problem	Sinus Problems	Stroke	Thyroid problem
Other	Have you ever had an adverse reaction or allergies to any medication or substance? Check all that apply.		Antibiotics
Dental Anesthetics	Acrylic	Aspirin	Barbiturates (sleeping pills)
Codeine or other pain medication	Latex	Metals	Sedatives
Sulfa drugs	Valium	Other	Are you being/have you ever been treated for cancer of any kind?
Are you currently taking or have you ever taken any bisphosphonate drugs?			
These include:			
alendronate (Fosamax)	clodronate (Ostac, Bonefos)	ibandronate (Boniva)	pamidronate (Aredia)
risedronate (Actonel)	tiludronate (Skelid)	zoledronic acid (Zometa)	Do you take or have you taken Phen-Fen or Redux?
Do you smoke or chew tobacco?	Do you use alcohol, cocaine, or other drugs?	Have you ever had any excessive bleeding requiring special treatment?	Have you been treated in a hospital in the last five years?
If female, please mark if you are:		Pregnant - If so, please enter your due date or week #	Trying to get pregnant
Nursing		On birth control	
Please list all current prescriptions:		Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:	

All of the above information is correct to the best of my knowledge. 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 understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature		
Date	---------- For office use ----------	
Notes		
Reviewed by	Title	Date

HIPAA Notice of Privacy Practices

HIPAA 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 the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and

other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your 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.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

- To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose

- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices

- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence

- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws

- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies

- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else

- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations..

- Uses or disclosures for health-related research

- Uses and disclosures to prevent a serious threat to health or safety

- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service

- Disclosures of de-identified information

- Disclosures relating to worker's compensation programs

- Disclosures of a "limited data set" for research, public health, or healthcare operations

- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures

- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. 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 the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- 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 provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of February 14, 2017, 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a

complaint.
For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:.

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Quail Ridge Dental to use and/or disclose my protected health information to carry out the following:

Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.

Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.

The day to day healthcare operations of your dental practice.

Additionally, I authorize you to share all my protected health information with the following individual(s):		**Name**	**Relationship**
Phone	**Name**	**Relationship**	**Phone**
Name	**Relationship**	**Phone**	

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature	
Date	**If signing on behalf of someone, explain your relationship to the patient:**

FOR OFFICE USE ONLY

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:	**Describe your good faith effort to obtain the individual's signature on this form:**
Office Personnel Signature	
Office Personnel Name	
Office Personnel Title	**Date**