PATIENT REGISTRATION

Patient's Name _____ Today's Date _____
Address _____ City _____ State ___ Zip _____
Birth Date _____/_____/_____ Sex M F Marital Status M S D W
Social Security # _____/____/_____
Home Phone ____/____/_____ Work Phone ____/____/_____Cell # ____/____/_____ E-Mail _____ Referred By _____

MEDICAL INFORMATION

Are you under the care of a MEDICAL DOCTOR? Yes No
If yes, for what? _____
Are you currently taking any MEDICATION? Yes No
If yes, please list name and dosage _____
WOMEN: Are you Pregnant? Yes No Nursing? Yes No Taking Birth Control? Yes No

PLEASE CIRCLE WHICH OF THE FOLLOWING YOUR HAVE HAD, OR HAVE AT THE PRESENT TIME

Aids/HIV Positive	**Anemia**	**Arthritis/Rheumatism**	**Artificial Heart Valve**
Artificial Joints	**Asthma**	**Blood Disease**	**Cancer**
Chemical Dependency	**Chemotherapy**	**Circulatory Problem**	**Cortisone Treatments**
Cough (Persistent)	**Diabetes**	**Emphysema**	**Epilepsy/Seizures**
Fainting	**Glaucoma**	**Headache**	**Heart Attack/Disease/Surgery**
Heart Murmur	**Hemophilia**	**Hepatitis A B C**	**Herpes/Cold Sores**
High Blood Pressure	**Jaw Pain**	**Kidney Problems**	**Liver Disease**
Mitral Valve Prolapse	**Nervous Problems**	**Pacemaker**	**Psychiatric Care**
Radiation Treatments	**Respiratory Disease**	**Rheumatic/Scarlet Fever**	**Shingles**
Shortness of Breath	**Spina Bifida**	**Stroke**	**Surgical Implant**
Thyroid Problem	**Tobacco Habit**	**Tonsillitis**	**Tuberculosis**
Ulcer/Colitis	**Venereal Disease**		

ALLERGIES

Aspirin Codeine Penicillin Erythromycin Latex (balloons, gloves etc.) Nitrous Oxide Local Anesthetic Others
_____

FAMILY PHYSICIAN _____ PHONE # _____

IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION I SHOULD KNOW ABOUT?

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible _____Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Home Phone _____/_____/_____ Cell # _____/____/_____ E-Mail _____
Social Security # _____/____/_____ Birth Date _____/_____/_____ Occupation _____
Employer _____ Address _____State ___ Zip _____ Work # _____/_____/_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or medication.
PATIENT/GUARIDAN SIGNATURE _____DATE_____

DENTAL HISTORY

Last COMPLETE dental exam, Date _____
Last FULL MOUTH X-RAYS, Date _____

Are you having PROBLEMS now?	**YES**	**NO**
WHAT? _____		
Is your present dental health POOR?	**YES**	**NO**
Do you wear DENTURES? (Partials or Full) _____	**YES**	**NO**
Are you UNHAPPY with your dentures?	**YES**	**NO**
Would you like to know more about PERMANENT REPLACEMENTS?	**YES**	**NO**
Are you APPREHENSIVE about dental treatment?	**YES**	**NO**
Have you had any PERIODONTAL (Gum) treatments?	**YES**	**NO**
Do your gums BLEED, or feel TENDER or IRRITATED?	**YES**	**NO**
Are your teeth SENSITIVE to hot, cold, sweets, or pressure? (please circle)	**YES**	**NO**
Are you UNHAPPY with the APPEARANCE of your teeth?	**YES**	**NO**
Are you aware of GRINDING or CLENCHING your teeth?	**YES**	**NO**
Do you have HEADACHES, EARACHES, or NECK PAINS?	**YES**	**NO**
Have you worn BRACES on your teeth? (Orthodontics)	**YES**	**NO**
Do you have DISCOLORED teeth that bother you?	**YES**	**NO**
Would you like your smile to LOOK BETTER or DIFFERENT?	**YES**	**NO**
Do you REGULARLY use DENTAL FLOSS?	**YES**	**NO**

Name of Previous Dentist & Address _____
Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment
FEAR of pain #_____ COST of treatment #_____ MISSING work time #_____ LACK of concern #_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	**Secondary Dental Insurance**
Insured's Name _____	**Insured's Name _____**
Insured's SS # _____	**Insured's SS # _____**
Insured's ID # _____	**Insured's ID # _____**
Insured's Birth Date _____/_____/_____	**Insured's Birth Date _____/_____/_____**
Insurance Co. Name _____	**Insurance Co. Name _____**
Insurance Co. Address _____	**Insurance Co. Address _____**
_____	**_____**
Insurance Co. Phone # _____/_____/_____	**Insurance Co. Phone # _____/_____/_____**

Insurance Co. Group # _____ Insurance Co. Group #_____

Employer Name _____ Employer Name _____

Employer Address _____ Employer Address _____

_____ _____

Employer Phone # _____ Employer Phone # _____

NOTICE OF PRIVACY PRACTICES

Zelienople Smiles

506A S. MAIN STREET, SUITE 2103

Zelienople, PA 16063

724-453-1200

FAX -724-452-1585

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason, except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for you care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using your healthcare. We will also 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.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.
You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $8.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact Officer: *Angel Kerns*

Telephone: *724-453-1200* **Fax:** *724-452-1585*

E-mail: Zelienoplesmiles@outlook.com

Address: 506A S. Main Street, Suite 2103

Zelienople, PA 16063

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name: _____

Address: _____City _____State _____Zip _____

Telephone : _____E-mail: _____

Social Security # _____-_____-_____ Date of Birth _____/_____/_____

SECTION B: To the Patient – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _*Angel Kerns*_____
Address: _____506*A S Main Street, Suite 2103* ____**City**_*Zelienople*___**State** _*PA*__**Zip** _*16063*__ **Telephone:** ____*724-453-1200*_____ **Fax:** _*724-452-1585*_____
E-mail: _Zelienoplesmiles@outlook.com_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____ YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

IMPORTANT INFORMATION ABOUT YOUR DENTAL INSURANCE

Our office is happy to help you file your insurance claims to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered and not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will only pay what it typically built into most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Human Resources Director can usually help you become familiar with your plan and its restrictions, and our office will assist you in maximizing your benefits.

OUR RESPONSIBILITIES:

1. **Complete your insurance claim forms and submit them to your carrier for you within 24 hours of treatment**
2. **Use current ADA coding for correct reporting of procedures**
3. **Accept direct payment from your insurance carrier and keep track of balances**
4. **If necessary, re-file your insurance a second time within a 60 day prior**

YOUR RESPONSIBILITIES:

1. **You may be asked to pay any deductibles and/or co-payments at time of treatment. Any balance remaining after insurance payment is due within 30 days and must be paid in full upon receiving your first statement from our billing service. Any unpaid balances will be subject to a monthly finance charge.**
2. **To provide our office with necessary information concerning your insurance coverage to allow for the correct filing of insurance claims.**
3. **To understand that your plan is a contract between you, your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make the plan pay.**
4. **Contact your insurance company when payment has not been made within a 60 day period**
5. **To pay any account balances not paid by the insurance after 2 billing attempts. You are ultimately responsible for all balances not paid by your insurance company.**
6. **Our office strives to use the most up to date techniques and materials. <u>PLEASE NOTE: WE DO NOT PLACE AMALGAM (SILVER) FILLINGS. WE USE RESIN FILLING MATERIALS, WHICH WE FEEL IS THE MOST ADVANCED MATERIAL AVAILABLE AT THIS TIME.</u> It is your responsibility to know if your insurance plan reimburses at the amalgam restoration level. Regardless of the material used in your restorations <u>you will be responsible</u> for the difference in insurance reimbursements.**

We thank you for choosing our office and we will do all we can to help you obtain the benefits you deserve. Please sign below. We will keep one copy in your file and give you a copy upon request for your records.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL COSTS OF ALL DENTAL TREATMENT. I GRANT THE RIGHT TO THE DENTIST TO RELEASE MY DENTAL RECORDS AND OTHER INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYERS.

_____ _____

Signature **Date**