# DENTAL REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## 2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## 3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

## 4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | |
|---|---|---|
| Bad breath | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No |
| Burning sensation on tongue | ☐ Yes | ☐ No |
| Chew on one side of mouth | ☐ Yes | ☐ No |
| Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No |
| Clicking or popping jaw | ☐ Yes | ☐ No |
| Dry mouth | ☐ Yes | ☐ No |
| Fingernail biting | ☐ Yes | ☐ No |
| Food collection between the teeth | ☐ Yes | ☐ No |
| Foreign objects | ☐ Yes | ☐ No |
| Grinding teeth | ☐ Yes | ☐ No |
| Gums swollen or tender | ☐ Yes | ☐ No |
| Jaw pain or tiredness | ☐ Yes | ☐ No |
| Lip or cheek biting | ☐ Yes | ☐ No |
| Loose teeth or broken fillings | ☐ Yes | ☐ No |
| Mouth breathing | ☐ Yes | ☐ No |
| Mouth pain, brushing | ☐ Yes | ☐ No |
| Orthodontic treatment | ☐ Yes | ☐ No |
| Pain around ear | ☐ Yes | ☐ No |
| Periodontal treatment | ☐ Yes | ☐ No |
| Sensitivity to cold | ☐ Yes | ☐ No |
| Sensitivity to heat | ☐ Yes | ☐ No |
| Sensitivity to sweets | ☐ Yes | ☐ No |
| Sensitivity when biting | ☐ Yes | ☐ No |
| Sores or growths in your mouth | ☐ Yes | ☐ No |

How often do you floss? _____

How often do you brush? _____

## 5 HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fainting or dizziness | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Heart Problems | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| | | High Blood Pressure | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Jaw Pain | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Tumor or growth on head or neck | ☐ Yes ☐ No |
| Congenital Heart Lesions | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | | |
| Cortisone Treatments | ☐ Yes ☐ No | Nervous Problems | ☐ Yes ☐ No | Ulcer | ☐ Yes ☐ No |
| Cough, persistent or bloody | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Emphysema | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No | | |
| Do you wear contact lenses? | ☐ Yes ☐ No | | | | |

**Women:**

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

| | |
|---|---|
| ☐ Aspirin | ☐ Local Anesthetic |
| ☐ Barbiturates (Sleeping pills) | ☐ Penicillin |
| ☐ Codeine | ☐ Sulfa |
| ☐ Iodine | ☐ Other _____ |
| ☐ Latex | _____ |

## 6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

# NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this health information. Please read it carefully and ask any questions.

## WHAT IS HEALTH INFORMATION:

Each time that a service is rendered or a procedure is done, even as simple as a routine blood pressure check, data and information are collected. This is health information or what is commonly referred to as information for or in the medical record or the patient record. Accurate, credible, and timely data and information are used by this facility as the basis for planning your care, as a means of having multiple healthcare providers know about your current health status, as a health legal document, as a record for billing purposes, as a source of data for research, planning, and marketing, as a source of required information for public health officials, and as a means to continue to improve the care that we provide. At this facility, we have always, and will continue to protect the privacy of your health information and the dignity of you as an individual. On July 6, 2001, the U.S. Federal Government passed compliance regulations that mandate all healthcare facilities, health plans, and clearinghouses to protect health information and inform consumers of the healthcare information practices of the facility.

## THE CONSUMER'S HEALTH INFORMATION RIGHTS:

This facility maintains a medical record for you containing medical information concerning you. With this in mind, you have the right to:

Request a restriction on use and disclosure of health information, although the facility is not required to comply (45 CFR 164.522)
Obtain a copy of this notice
Inspect and receive a copy of your medical record (45 CFR 164.524)
Amend your medical record (45 CFR 164.528)
Obtain an accounting of disclosures of your medical record (45 CFR 164.528)
Request your medical record by alternative means or location
Revoke your authorization to use or disclose your health information except to the extent that action has already been taken

## THIS FACILITY'S RESPONSIBILITIES:

This facility's mission of quality service and respect of the individual has always taken into account protecting health information privacy. Our responsibilities are to:

Maintain the privacy of your health information
Provide you this notice of health information practices
Notify you if we are unable to satisfy a request
Accommodate all reasonable requests while maintaining quality care and respect for you
Make you aware of all health information practice policy changes
We will not use or disclose your health information without your approval except as stated in this notice.
When health information is disclosed as above, it will be disclosed at the minimum necessary level.

## TO REQUEST FURTHER INFORMATION OR ASK QUESTIONS:

If you would like further information or have questions, this facility employs a HIPAA Compliance Officer who can be reached at 412-396-1387.

If you believe that your privacy rights have been violated, you can file a complaint with the Compliance Officer or with the Secretary of Health and Human Services. There will be no penalty or retaliation for filing a complaint.

### Examples of Permitted Types of Uses and Disclosures of Health Information:

This facility may use or be required to use your health information without your authorization or consent for normal business activities as follows:

**For Care and Treatment:** Health information obtained by a healthcare practitioner such as a physician, nurse, or therapist, will be entered into your medical record and used to determine a plan of care. For example, healthcare members will write and read what others have written such that your care can be coordinated and everyone is aware of how you are responding to your treatment plan. When you are discharged from this facility, your health information may go with you such that future healthcare providers will have a record of your care. Your health insurer may disclose health information to the sponsor of the plan.

**For Billing and Payment:** In addition to demographic information, information on a bill sent to an insurer may include health information. This health information is restricted to that which is needed for the financial transactions.

**For Healthcare Operations:** In order to provide quality care, healthcare providers at this facility may use your health information, for example, to analyze the care, treatment, and outcomes of your medical case and of others. This health information will be used to continually improve the care of the services that we provide to you.

**For Directory Purposes:** We will use your name, facility location, general medical condition, and religious affiliation for directory purposes unless you instruct us not to. This health information is only for the use of clergy and to people who ask for you specifically by full name (although religious affiliation will not be given to the latter).

**For Business Associates:** In order to provide quality care, this facility requires business services such as pharmacy, medical equipment, medical laboratories, information technology, etc.. These services will have use of your health information as it pertains to their service delivery. Also, business associates must follow our standards for protecting your health information and sign a business associate agreement. In addition, the business associates must follow the HIPAA Security Rule as specified in the Health Information Technology for Economic and Clinical Health Act (HITECH)/Energy and Commerce Recovery and Reinvestment Act, Subtitle D, Section 4401.

**For Clergy:** Unless you specify that you object, health information such as your name, room number, and general medical condition will be given to clergy for professional purposes only.

**For Notification:** We may use or disclose health information, such as your general condition, to notify or assist in notifying a family member or person responsible for your care.

**For Communication:** We may use or disclose health information relevant to your care to family member's or those that you deem responsible for your care on a need to know basis.

**For Research:** We may disclose health information to researchers if they have appropriate consent forms and the research has been approved by our institutional review board. The researchers will be held to this facility's health information privacy standards.

**For Funeral Directors:** We may disclose health information to funeral directors in accordance with state laws and for professional purposes only.

**For Organ Procurement Organizations:** Consistent with applicable law, we may disclose health information to organ procurement organizations or organizations involved in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

**For Marketing Purposes:** We may contact you to provide information on appointment reminders or alternative treatments and services that may benefit you given your medical condition. In addition, a covered entity or business associate shall not directly or indirectly receive remuneration in exchange for any protected health information of an individual unless the covered entity obtained from the individual, in accordance with section 164.508 of title 45, Code of Federal Regulations, a valid authorization that includes, in accordance with such section, a specification of whether the protected health information can be further exchanged for remuneration by the entity receiving protected health information of that individual. Exceptions under HITECH include, when the purpose of the exchange is for research, public health, , treatment, health care operations, providing an individual with a copy of their protected health information, and for remuneration that is provided by a covered entity to a business associate for activities involving the exchange of protected health information that the business associate undertakes on behalf of and at the specific request of the covered entity pursuant to a business associate agreement. The price charged must reflect not more than the costs of preparation and transmittal of the data for such purpose.

**For Fundraising:** We may contact you for fundraising efforts that are aligned with the mission of this facility.

**For the Food and Drug Administration:** As requested or required by the FDA, we may disclose health information relative to an adverse health condition related to food, food supplements, product and product defects related to food, or post marketing surveillance information to allow product recalls, repairs, or replacements.

**For Workers Compensation Issues:** In compliance with Worker's Compensation laws, health information may be revealed to the extent necessary to comply with the law and your individual case.

**For Public Health Requirements:** As required by law, health information may be disclosed to public health or legal authorities for the jurisdiction of disease, injury, or disability prevention or control.

**For Correctional Institutions:** Should you be an inmate in a correctional institution, health information may be disclosed to the institution or its agents that which would be necessary for your health and safety and the health and safety of other individuals.

**For Law Enforcement Agencies:** Health information may be disclosed to law enforcement agencies for purposes required by law or subpoena.

**For Judicial and General Administrative Proceedings:** Patient health information may be released per minimum necessary requirements for proceedings.

**For Healthcare Oversight:** Patient health information may be used by health oversight agencies for activities such as audits, inspections, and licensure activities.

**For Specialized Government Functions:** In the event that appropriate military authorities require information, it may be released at the minimum necessary level.

**For Victim of Abuse, Neglect, and Domestic Violence:** Information may be released to social service agencies or protective services in order to protect an individual.

Other uses and disclosures are to be made with your written authorization and you may revoke such authorization at any time.

Effective Date: 03/16/09

Alfred W. Hollis, D.D.S. PLLC
157 Lake Avenue, Saratoga Springs, NY 12866

OFFICE HOURS:
Monday –Thursday 8:00am -5:00pm
Closed daily between 1pm-2pm

RELEASE: I give Alfred W. Hollis, D.D.S. PLLC permission to use my x-rays, models, and clinical photographs in lecture or clinical publications.

BROKEN APPOINTMENTS: If you must disappoint us for the time planned exclusively for your dental needs, kindly give us at least 48 hours to avoid a failed appointment charge.

FINANCIAL SERVICES:
Dental care is an excellent investment in an individual's health and wellbeing. More and more Americans today are placing aesthetic and reconstructive dentistry at the top of their self-improvement list. It is our strong belief that your dental treatment should not be compromised for financial reasons or third party influence. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are pleased to offer several affordable financial options to you.

## Cash, Check, VISA, MasterCard, Discover, or ATM/Debit Cards:

You are ultimately responsible for all fees incurred regardless of whether or not you have dental benefits.
Insurance patient's estimated portion not covered or not directly paid to Alfred W. Hollis D.D.S. PLLC by their primary insurance is due at the time of service. Note that even with a pre-authorization an insurance company doesn't issue guarantee of payment.

## Easy Monthly Payment Plans:

While we don't offer in office financing, we have been able to establish relationships with several companies that can help you to finance your dental treatment. Plans vary, but most will offer interest free plans between 6-12 months. Please feel free to inquire about this option at the time of your appointment.

FEES: As a courtesy to you, we will honor plan fees for 90 days from the time of treatment plan estimate. Understand that treatment needs may possibly change during the course of treatment; you will be advised as to the appropriate course of treatment should this occur.

I understand and accept the client services information and my responsibility as a patient.

Patient (or Guardian's) Name Signature Date

# HIPAA-Consent Form For Patients

Alfred W. Hollis, D.D.S. PLLC
157 Lake Avenue, Saratoga Springs, NY 12866

## ACKNOWLEDGMENT AND CONSENT

Acknowledgement of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations.

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of the Patient or Personal Representative

Print Name of Patient or Personal Representative
(including description of legal authority)

_____

Date