ROCKY HILL FAMILY Dentistry

Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. _____

Cell Phone: ( ) _____ Work Phone: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: __/__/____ Age: _____

Who may we thank for referring you to us? _____

DENTAL INSURANCE INFORMATION

Who is the responsible Party? _____ Relation: _____

Spouse: _____

Employer: _____ Insurance Company: _____

Policy Holder Name: _____ Group ID: _____

Member ID: _____ Member Social Security Number: _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Have you been under a physician's care, outpatient or in patient, during the past two years?

☐Yes ☐No If so, why? _____

Please list any drugs or medications you are taking and dosage _____

_____

Have you ever taken bone loss prevention drugs such as ☐Fosamax, ☐Actonel, ☐Boniva, *or* ☐ Other bisphosphonates? Dosage: _____

Women — Are you: ☐Pregnant? ☐Nursing? ☐Taking oral contraception?

Please list any allergic or adverse reaction to any substance or medication _____

_____

If you have had any of the following or have at present, mark yes. If not, mark no.

	YES	NO		YES	NO		YES	NO
Heart Problems	☐	☐	Epilepsy	☐	☐	Cold Sore/Fever Blister	☐	☐
Heart Pacemaker	☐	☐	Fainting	☐	☐	Osteoporosis	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐	Tuberculosis	☐	☐
Heart Attack/Stroke	☐	☐	Hemophilia	☐	☐	Diabetes	☐	☐
Angina/Chest Pain	☐	☐	Kidney Disease	☐	☐	Sinus Problems	☐	☐
Frequent Headaches	☐	☐	AIDS/HIV	☐	☐	Liver Disease	☐	☐
Excessive Bleeding	☐	☐	Arthritis	☐	☐	Respiratory Problems	☐	☐
Circulatory Problems	☐	☐	Leukemia	☐	☐	Thyroid Problems	☐	☐
Artificial Heart Valve	☐	☐	Artificial Joint	☐	☐	Chemo/Radiation	☐	☐
Mitral Valve Prolapse	☐	☐	Latex Allergy	☐	☐	Tumors	☐	☐
Heart Murmur	☐	☐	Blood Thinners	☐	☐	Rheumatic Fever	☐	☐
Hepatitis A, B, C	☐	☐	Stomach Ulcers	☐	☐	Emphysema/Cough	☐	☐
Hay Fever/Hives	☐	☐	Sickle Cell	☐	☐	Seizures	☐	☐
Neurological Issues	☐	☐	Nervous/Anxiety	☐	☐	Psychiatric Care	☐	☐

Are there any other medical conditions to disclose? _____

_____

ROCKY HILL FAMILY Dentistry

HIPAA Information Form

I understand that, by signing below, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used by the aforementioned dental practice, but it is not mandatory for me to sign in order to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly such as a physician, dentist, specialist, pharmacist, or emergency medical personnel.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and dental certificates.

I have read or waived my right to read the aforementioned dental practice's *Notice of Privacy Practices*, and may request a copy of this written statement at any time in the future. In addition, I acknowledge that this statement may be updated from time to time, and I am entitled to obtain the most recent copy of the *Notice of Privacy Practices* statement at any future date.

I understand that I may request, in writing, that Rocky Hill Family Dentistry restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand Rocky Hill Family Dentistry is not required to agree to my requested restrictions, but if the dental practice does agree, then the dental practice is bound to abide by such restrictions.

I consent to the following person(s) to receive my personal dental and medical information. **Please list all names on this form:**

1. _____

2. _____

3. _____

I understand that I may revoke this consent, in writing, at any time, except to the extent that you have not taken action relying on this consent.

Patient Name: _____ **Date:** _____

Patient Signature (Guardian if Minor): _____

May we send you text or e-mail messages? Yes ☐ No ☐

Emergency Contact Information Name: _____

Cell Phone: ( ) _____ Work Phone: ( ) _____

ROCKY HILL FAMILY Dentistry

Notice of Privacy Practices

Protecting your Confidential Health Information is important to us. **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.**

In 1996, a federal program called the Health Insurance Portability & Accountability Act (HIPAA) began. It requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally be kept properly confidential. This Act gives you, the patient, the rights to understand and control how your health information is used. If your personal information is misused, there are penalties for covered entities.

We may use and disclose dental/medical information about you in the following applications.

TREATMENT means providing and coordinating your dental/medical care with one or more providers. An example would be working with an orthodontist.

PAYMENT means activities including billing, collections, claims management, and determinations of eligibility and coverage to payment from you, an insurance company, or another third party. An example would be sending a claim to your insurance company for payment.

HEALTHCARE OPERATIONS means using your health information for quality assessment, improvement activities, cost analysis, business activities, and customer service. An example would be providing an accountant with financial information for taxes.

We may contact you for appointments and information about our dental services.

We may use health information about you in professional study groups after removing names, birthdays, phone numbers, and addresses. You may revoke authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your prior authorization.

Your **HEALTH INFORMATION RIGHTS** include Access, Disclosure Accounting, Right to Request a Restriction, Alternative Communication, and Amendments. You must provide a written request on what information you want restricted, whether it is to not use or to not disclose, and to whom you want the restrictions to apply. We are not required to agree to a requested restriction; however, if we do we must abide by it. You may ask us for more written information on your rights.

RIGHT TO NOTIFICATION OF A BREACH means you will receive notifications of breaches of your unsecured protected health information as required by law.

IF YOU HAVE ANY QUESTIONS, our Privacy Official is Jan Henley D.D.S., 7427 Northshore Drive, Knoxville, Tennessee 37919

Patient Name:_____ **Date:**_____

ROCKY HILL FAMILY Dentistry

Consent for Treatment & Financial Agreement

1. I hereby authorize the doctor(s) or designated staff to take x-rays, create study models, photographs, and other diagnostic aids deemed appropriate by the doctor(s) to make a thorough diagnosis of (name of patient) 's dental needs.
2. Upon such diagnosis, I authorize the doctor(s) to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctors' or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment, and health care operations.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2 % late charge (18% APR) may be added to my account. If necessary, collection and/or legal fees of 50% will be added to the balance due.
6. If you have dental insurance we will gladly file it for you, provided you furnish us with all the correct information at the time of your appointment. **Please understand that your insurance is a contract between you and the insurance company or you, your employer and the insurance company. We are not part of that contract, and filing your insurance is a courtesy. All charges are your responsibility from the date of service, and we ask that the estimated portions not covered by insurance (UCR-difference) be paid at the time of service.**
7. An appointment made is an agreed upon commitment set aside for your dental treatment. Obviously, there are situations for both the patient and our office that may result in a need to change or miss an appointment. However, we believe two or more cancellations and/or failed appointments without cause reflects a lack of commitment to your oral health and a lack of consideration for our dental practice. Your signature indicates we will have a mutual respect for each other's time.

Patient Name: _____ **Date:** _____

Patient Signature: _____

Parent/Responsible Party Signature: _____ **Relationship:** _____

Witness: _____