MY FAMILY DENTAL CENTERS

www.MyFamilyDentalCenters.com

PATIENT INFORMATION

PATIENT NAME: _____ PREFERRED NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

MALE / FEMALE **SINGLE / MARRIED**

SEX: _____ AGE: _____ DOB: _____ SOCIAL SECURITY #: _____ RELATIONSHIP STATUS: _____

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE

PRIMARY INSURED: (SUBSCRIBER) _____

RELATION TO PATIENT: _____ BIRTH DATE: _____ SUBSCRIBER ID#: _____ GROUP#: _____

SUBSCRIBER EMPLOYER OR PLAN SPONSOR: _____

INSURANCE COMPANY: _____

ADDITIONAL INSURANCE

SECONDARY INSURED: (SUBSCRIBER) _____

RELATION TO PATIENT: _____ BIRTH DATE: _____ SUBSCRIBER ID#: _____ GROUP#: _____

SUBSCRIBER EMPLOYER OR PLAN SPONSOR: _____

INSURANCE COMPANY: _____

AUTHORIZATION AND RELEASE

I authorize my insurance company to pay Sossaman Family Dental all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Sossaman Family Dental may use my health care information and may disclose such information to my 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, as pertaining to the HIPPA guidelines.

PATIENT/GUARDIAN SIGNATURE: _____ PRINTED NAME: _____ DATE: _____

DENTAL HISTORY

REASON FOR TODAYS VISIT: _____

IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE OF YOUR SMILE? _____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

DATE OF LAST DENTAL CLEANING: _____ DATE OF LAST DENTAL X-RAYS/EXAM: _____

MARK IF YOU HAVE HAD/HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

- ❑ BAD BREATH
- ❑ BLEEDING GUMS
- ❑ JAW PAIN
- ❑ SENSITIVITY TO COLD/HOT
- ❑ LOOSE OR BROKEN TEETH
- ❑ LOOSE OR BROKEN FILLINGS
- ❑ CLICKING OR POPPING JAW
- ❑ GRINDING TEETH
- ❑ SENSITIVITY TO SWEETS
- ❑ SORES OR GROWTHS IN THE MOUTH
- ❑ SENSITIVITY WHEN BITING
- ❑ FOOD COLLECTION BETWEEN TEETH

MEDICAL HISTORY

PHYSICIANS NAME: _____ CITY/STATE: _____

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? YES / NO

IF YES, DESCRIBE: _____

HAVE YOU HAD A BLOOD TRANSFUSION? YES / NO

IF YES, GIVE APPROXIMATE DATE(S): _____

HAS IT EVER BEEN NECESSARY FOR YOU TO PRE-MEDICATE FOR A DENTAL APPOINTMENT? YES / NO

IF YES, DESCRIBE: _____

ARE YOU/HAVE YOU TAKEN ANY BISPHOSPHONATE MEDICATION? YES / NO

IF YES, DESCRIBE: _____

CIRCLE ANY OF THE FOLLOWING CONDITIONS, PAST OR PRESENT:

ANEMIA	YES/NO	CIRCULATORY PROBLEMS	YES/NO	HEPATITIS	YES/NO	SCARLET FEVER	YES/NO
ARTHRITIS, RHEUMATISM	YES/NO	CORTISONE TREATMENT	YES/NO	HIGH BLOOD PRESSURE	YES/NO	SHORTNESS OF BREATH	YES/NO
ARTIFICIAL HEART VALVES	YES/NO	PERSISTENT COUGH	YES/NO	HIV/AIDS	YES/NO	STROKE	YES/NO
ARTIFICIAL JOINTS	YES/NO	DIABETES	YES/NO	KIDNEY DISEASE	YES/NO	SWELLING OF FEET / ANKLES	YES/NO
ASTHMA	YES/NO	EPILEPSY	YES/NO	LIVER DISEASE	YES/NO	THYROID PROBLEMS	YES/NO
BACK PROBLEMS	YES/NO	FAINTING	YES/NO	MITRAL VALVE PROLAPSE	YES/NO	TOBACCO USAGE	YES/NO
BLOOD DISEASE	YES/NO	GLAUCOMA	YES/NO	PACEMAKER	YES/NO	TUBERCULOSIS	YES/NO
CANCER	YES/NO	HEART MURMUR	YES/NO	RADIATION TREATMENT	YES/NO	TONSILLITIS	YES/NO
CHEMOTHERAPY	YES/NO	HEART PROBLEMS	YES/NO	RESPIRATORY DISEASE	YES/NO	ULCERS	YES/NO
CHEMICAL DEPENDENCY	YES/NO	HEMOPHILIA	YES/NO	RHEUMATIC FEVER	YES/NO	VENEREAL DISEASE	YES/NO

WOMEN: ARE YOU PREGNANT? **YES / NO** ARE YOU NURSING? **YES / NO** TAKING BIRTH CONTROL? **YES / NO**

LIST MEDICATIONS YOU ARE CURRENTLY TAKING: _____

LIST ANY ALLERGIES YOU ARE AWARE OF: _____

IN OFFICE USE

HEAD & NECK EXAM	WNL or	_____
SOFT TISSUE	WNL or	_____
TMJ EXAM	WNL or	_____
OCCLUSION	CLASS	I II III
ORTHO	YES	NO

UPDATED MEDICAL HISTORY

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I WILL NOT HOLD THE DOCTOR OR ANY MEMBERS OF THEIR STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE: PRINTED NAME: DATE:

_____ _____

DR.'S SIGNATURE: DATE:

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Financial Guidelines

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following financial guidelines.

Payment Options:
Payment is due at the time of service. Pre-payment on services over $1000.00, or in cash, will receive 5% off our usual and customary treatment fees. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. We offer interest-free financing thru CareCredit and Chase (O.A.C.).

☐ ***Are you interested in interest-free financing with monthly payment options?***

Insurance:
As a courtesy, we will file your insurance claim for you. Be prepared to pay the estimated amount determined not payable by your insurance company, such as a deductible and/or co-pay. Please understand that this is an **estimate**, and you, the patient, are ultimately responsible for any treatment costs not covered by your insurance plan.

Return Check Fee:
A charge of ***$25.00*** will be applied to your account for any unpaid checks returned by your bank.

Failed Appointment Fees:
We reserve the right to charge a $50.00/per hour fee for appointments cancelled or broken (including not showing-up) without a 48-hour advance notice. We value *your* time, please value *ours*.

Legal Fees:
We reserve the right to charge a patient for legal fees incurred by My Family Dental Centers, et al, for efforts to collect any monies due. I understand that My Family Dental Centers, et al, cannot guarantee or make any assurances in regards to dental treatment benefits and/or coverage. I also acknowledge that I am responsible for payment of all my dental fees regardless of any dental insurance or plan coverage.

Our Promise To You:
We warranty our work and services, however this warranty will be void if you fail to maintain regularly scheduled hygiene appointments as determined by our oral healthcare professionals.

Signature of Patient/Guardian:

Patient/Guardian Signature	Printed Name	Date

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NOTICE OF PRIVACY PRACTICES

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION IS IMPORTANT TO US!

NOTICE OF PRIVACY PRACTICES

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.

OUR PROMISE!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPPA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

SO WHAT HAS CHANGED? WHY A PRIVACY POLICY NOW? VERY GOOD QUESTIONS!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your **HEALTH INFORMATION** only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

HOW YOUR HEALTH INFORMATION MAY BE USED

TO PROVIDE TREATMENT

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you services and/or treatment.

TO OBTAIN PAYMENT

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

TO CONDUCT HEALTH CARE OPERATIONS

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situation experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process and certification, licensing or credentialing activities.

IN PATIENT REMINDERS

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

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ABUSE OR NEGLECT
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

PUBLIC HEALTH AND NATIONAL SECURITY
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

FOR LAW ENFORCEMENT
As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

FAMILY, FRIENDS AND CAREGIVERS
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

PATIENT ACKNOWLEDGMENT

Patient Name(s): _____

_____

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by your signature. We look forward to guiding you with your dental care.

_____ _____

PATIENT SIGNATURE DATE

PATIENT RIGHTS
This new law is careful to describe that you have the following rights related to your health information.

RESTRICTIONS
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our clients.

CONFIDENTIAL COMMUNICATIONS
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

INSPECT AND COPY YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

AMEND YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

DOCUMENTATION OF HEALTH INFORMATION
You have the right to ask us for a description of how and where your health information was used by our office for any reason other then for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

REQUEST A PAPER COPY OF THE NOTICE
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.