Patient Registration and Health History

1st Tell Us About You

Date: ❑ male ❑ female

Name:

I prefer to be called:

Address:

City: State: Zip:

Home Phone #

Cell #

E-mail:

Birthdate: Age:

❑ married ❑ single ❑ divorced ❑ widowed

Social Security #:

Who may we thank for referring you:

If this appointment is for *your child* please Complete the following:

Name: ❑ male ❑ female

Nickname:

Address:

City: State: Zip:

Home Phone #

Birthdate: Age: Grade:

School:

3rd Getting to Know You

Other family members seen by us:

Where / When is the best times to reach you?

Previous/Present dentist:

Last dental visit:

Person to contact in an emergency:

Phone #

Address:

2nd About Your Insurance

Primary dental insurance carrier

Insurance company:

Insurance Co. address:

Employee:

Employee's birthdate: Relationship:

Group #

Date Employed:

Social Security #

Thank You!

4th Account Information

Person financially responsible for this account?

Name: Relationship:

Drivers License #

Your name:

Employer:

Business Address:

Business Telephone: Ext:

Spouses Name:

Employer:

Business Address:

Business Telephone Ext:

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs. I understand these will be used as record of my care and may be used for case visualization and educational purposes in the dental office or on the office website. I further understand that if the photographs / videos are used in any publication or demonstration, my name or identifying information will be kept confidential. I do not expect compensation, financial or otherwise for the use of these photographs.

2. Upon such diagnosis, I authorize doctor 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 medications 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 hereby authorize my dental benefits to be paid directly to Dr. Pedley. To expedite this I authorize release of any information relating to my treatment.

5. Lastly, 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 the agreed upon dates, I understand that a 1½% late charge (18% APR) may be added to my account.

_____

Patient / Responsible Party Date

Acknowledgement of Receipt of Notice of Privacy Practices

The office of David S. Pedley, D.D.S. holds your personal information at the highest of confidentiality. I am aware of this office's Notice of Privacy Practices.

_____

Patient / Responsible Party Date

****You may refuse to sign this acknowledgement****

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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other: (please specify)

PATIENT NAME	DENTAL HISTORY
PATIENT ACCOUNT NUMBER	MEDICAL ALERT

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form.

All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit? _____ Last Dental Cleaning? _____ Last Full Mouth's X-Rays? _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ..... Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? ..... Yes No
Sweets? ..... Yes No
Biting or Chewing? ..... Yes No
Have you noticed mouth odors or bad tastes? ..... Yes No
Do you frequently get cold sores, blisters, or any other oral lesions? ..... Yes No
Do your gums bleed or hurt? ..... Yes No
Have your parents experienced gum disease or tooth loss? ..... Yes No
Have you noticed any loose teeth or a change in your bite? ..... Yes No
Does food tend to become caught in between your teeth? ..... Yes No
If yes – Where? _____

Do you:

Clench or grind teeth while awake? ..... Yes No
Bite your lips or cheeks regularly? ..... Yes No
Hold foreign object with your teeth? (pencils, pipe, pins, nails, fingernails) ..... Yes No
Mouth breathe while awake or asleep? ..... Yes No
Have tired jaws, especially in the morning? ..... Yes No
Smoke/chew tobacco? ..... Yes No

Have you ever had:

Orthodontic treatment? ..... Yes No
Oral Surgery? ..... Yes No
Periodontal treatment? ..... Yes No
Your teeth ground or the bite adjusted? ..... Yes No
A bite plate or mouth guard? ..... Yes No
A serious injury to the mouth or head? ..... Yes No
If yes - Please describe injury _____

Have you experienced:

Clicking or popping of the jaw? ..... Yes No
Pain? (joint, ear, side of face) ..... Yes No
Difficulty in opening or closing the mouth? ..... Yes No
Difficulty in chewing on either side of the mouth? ..... Yes No
Headaches, neck aches, or shoulder aches? ..... Yes No
Sore muscles (neck, shoulders) ..... Yes No

Are you satisfied with your teeth's appearance? ..... Yes No
Would you like to keep all of your teeth for all of your life? ..... Yes No
Do you feel nervous about having dental treatment? ..... Yes No
If yes - what is your biggest concern? _____

Have you ever had an upsetting dental experience? ..... Yes No
If yes, Please describe: _____

Is there anything else you would like us to be aware of regarding your dental health or treatment ? ..... Yes No
If yes, Please describe _____

PATIENT NAME	MEDICAL HISTORY
PATIENT ACCOUNT NUMBER	MEDICAL ALERT

1. Have you been under the care of a medical doctor during the past two years? ……..… Yes No

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? …… Yes No
3. Are you taking any medication, drugs, or pills now? …… Yes No

   If so, please list the name and dosage? _____
4. Are you aware of having an allergic (or adverse reactions) to any medication or substance? ……... Yes No

   If yes, please list? _____
5. Have you been a patient in the hospital during the past five years? …… Yes No
6. Indicate which of the following you have had, or have at the present time. Circle "yes" or "no" to each line item.

Heart (Surgery, Disease, Attack).....	Yes	No	Ulcers……	Yes	No	Hepatitis A (infectious) B (serum)…	Yes	No
Chest Pain……	Yes	No	Diabetes……..……..…	Yes	No	Venereal Disease……..	Yes	No
Congenital Heart Disease……	Yes	No	Thyroid problems…. …….	Yes	No	A.I.D.S……..…….	Yes	No
Heart Murmur……..……	Yes	No	Glaucoma……	Yes	No	H.I.V. Positive……..……..	Yes	No
High Blood pressure……	Yes	No	Contact Lenses……	Yes	No	Cold Sores/Fever blisters…….…..	Yes	No
Mitral Heart Valve……	Yes	No	Emphysema…….……	Yes	No	Blood transfusion…….……..	Yes	No
Artificial Heart Valve…….……	Yes	No	Chronic cough……..…	Yes	No	Hemophilia.……..…….	Yes	No
Heart Pacemaker…….……	Yes	No	Tuberculosis…….….	Yes	No	Sickle Cell Disease.……..……..	Yes	No
Rheumatic Fever…….……	Yes	No	Asthma……...….	Yes	No	Bruise Easily……..…...…….	Yes	No
Arthritis/Rheumatism…..……	Yes	No	Hay Fever……..... ..	Yes	No	Liver Disease……..…….	Yes	No
Cortisone Medicine……	Yes	No	Latex Sensitivity…….……	Yes	No	Yellow Jaundice…….…...……	Yes	No
Swollen Ankles……..……	Yes	No	Allergies or Hives……..….	Yes	No	Neurological Disorders……	Yes	No
Stroke…….……	Yes	No	Sinus trouble……..….	Yes	No	Epilepsy/Seizures……	Yes	No
Diet (Special/Restricted)……	Yes	No	Radiation Therapy..……...	Yes	No	Fainting or Dizzy Spells……..	Yes	No
Artificial Joints (hip, knee, etc.)…	Yes	No	Chemotherapy……...	Yes	No	Nervous/Anxious……..……	Yes	No
Kidney Trouble…….	Yes	No	Tumors……..….	Yes	No	Psychiatric/Psychological Care……	Yes	No

7. Do you use more than two pillows to sleep..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? .....Yes No

   If yes, please list: _____
10. Women: Are you: Pregnant? Yes No (if yes - #, _____ Months) Nursing? Yes No Taking birth control pills? Yes No

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, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ **Date** _____

History Review

Doctor Signature _____ Date _____

Our Financial Policy

Our patients are expected to pay cash, check or credit card the day the service is rendered, unless specific arrangements are made in advance.

For those patients covered by insurance we will accept assignment of benefits. This means you must sign the portion of your insurance form that assigns payment to our office. Insurance benefits are a contract between you and your insurance company. The coverage you will receive depends on the quality of the plan purchased by your employer. Patients are responsible for paying their deductible and co-payments at the time of service. We will provide an *estimate* of coverage but it is just that – "an estimate." Patients are also responsible for paying all charges not covered by their insurance plans. We will submit a claim up to two times per appointment; further insurance appeals become your responsibility.

The insurance company needs to have paid within 60 days. Unpaid claims immediately become due and must be paid by the patient.

This office will accept assignment for only the primary insurance coverage. Secondary insurance coverage must be paid to the patient.

Our office cannot carry balances longer than 90 days. Patients will be informed that their account is delinquent so they can avoid collection action. If collection action becomes necessary, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at the maximum of 33% of the debt and all costs, and expenses including reasonable attorney fees, we incur in such collection efforts.

A service charge will be assessed for all returned checks. Interest charges are applied to accounts with balances older than 30 days.

I have read and accept the above Financial Policy.

_____

Patient / Guardian signature

David Pedley, D.D.S.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or

- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health

information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Carolyn Pedley
Telephone: 956-541-8200 Fax: 956-541-8240
Address: 127 E. Price Rd, Brownsville TX 78521
E-mail: drpedley@brownsvillesmiles.com