Dental Registration

Patient First Name:_____ Last Name:_____ MI:_____

Gender: ◯Female ◯Male Preferred Name:_____

Birth Date:_____ Social Security #_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

◯Minor ◯Single ◯Married ◯Divorced ◯Widowed

Address:_____City:_____State:_____Zip: Code_____

Email:_____

Employer:_____ Employer Phone #_____

In case of an emergency, who should we contact? _____

Relationship:_____ Phone #_____

Primary Medical Doctor_____Location_____

Preferred Pharmacy_____Location_____

How did you hear about our office: ◯ Internet Search ◯ TV ◯ Insurance Provider
Family/Friend:_____

Guardian/Spouse Contact Information

First Name:_____ Last Name:_____MI:_____

Gender: ◯Female ◯Male Preferred Name:_____

Birth Date:_____ Social Security #_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Address:_____City:_____State:_____Zip: Code_____

Employer:_____ Employer Phone #_____

Primary Dental Insurance

****PLEASE TEXT US A PHOTO OF THE FRONT AND BACK OF YOUR DENTAL INSURANCE CARD(S)****

605 339 0219

Name of the insured:_____

Name of the Policy Holder:_____

Relationship of Policy Holder to the insured: ◯ Self ◯ Spouse ◯ Child ◯ Other:_____

Policy Holder Date of Birth:_____

Policy Holder Social Security Number:_____

Name of Insurance Company:_____

Insurance Company Phone Number:_____

Member ID Number:_____

Group Number:_____

Payer ID Number (if applicable):_____

Secondary Dental Insurance

Name of the insured:_____

Name of the Policy Holder:_____

Relationship of Policy Holder to the insured: ◯ Self ◯ Spouse ◯ Child ◯ Other:_____

Policy Holder Date of Birth:_____

Policy Holder Social Security Number:_____

Name of Insurance Company:_____

Insurance Company Phone Number:_____

Member ID Number:_____

Group Number:_____

Payer ID Number (if applicable):_____

Dental History

Reason for today's visit

Former Dentist/Location

Date of last dental exam

Date of last x-rays

How often do you brush?

How often do you floss?

Please check to indicate if you have any of the following

☐ Bad breath	☐ Bleeding of gums	☐ Blisters on lips or mouth
☐ Burning sensation on tongue	☐ Chew on one side of mouth	☐ Popping or jaw pain
☐ Mouth piercings	☐ Fingernail biting	☐ Food collected in teeth
☐ Lip or cheek biting	☐ Grinding teeth	☐ Gums swollen or tender
☐ Orthodontic treatment	☐ Loose teeth or broken filling	☐ Mouth breathing
☐ Sensitivity to sweets	☐ Pain around ear	☐ Periodontal treatment
☐ Dry mouth	☐ Sensitivity to biting	☐ Temperature sensitivity

Family Dentistry of Sioux Falls
Put a Smile in your life

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

NO to all

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature: _____ **Date:** _____

Financial Policy

Thank you for choosing Family Dentistry of Sioux Falls as your dental health care provider. We are committed to building a successful dentist-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities as a patient at our office.

Patient responsibility
It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc). If a patient has dental insurance, the patient is expected to present an insurance card at each visit. You will also be asked to update patient paperwork, such as dental history, patient demographics, and medical history when these updates are due.

Insurance:
For patients with dental insurance, your dental benefits policy is a contract between you, your employer, and the dental benefits company. While we will assist you with understanding your benefits and submitting your claims, the ultimate responsibility lies with the patient. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Policy holder social security number and insurance policy group number are also necessary for submitting claims. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If the final insurance payment differs from the estimated patient portion given on a treatment estimate, the patient is responsible for the difference in full. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to our office or pay the bill directly. Our dentists at Family Dentistry of Sioux Falls are preferred providers with multiple insurance companies as a benefit to our patients. Although we are contracted with many insurance carriers, our services may not be covered by your particular insurance plan.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your dental insurance carrier with a copy of the workers' compensation insurance denial. If your dental insurance carrier's claim is denied, you will be responsible for payment in full.

Missed Appointments:
Family Dentistry of Sioux Falls requires a 24-hour notice to reschedule or cancel an appointment. We understand that situations outside of a patient's control can occur; however, if three last minute cancellations or missed appointments occur with less than a 24-hour notice, you may be placed on a short call list or may be dismissed from our office.

Dental X-rays:
Our dentists encourage our patients to discuss dental treatment recommendations, including the need for dental X-rays during their dental appointment. If a patient is unwilling to follow the dentist's recommendations for type or frequency of dental x-rays, the patient may be asked to seek a second opinion or to find a different dental provider.

Dental Record Copies
Patients requesting copies of dental records must sign our Records Release Form before records will be released. A copy fee for dental records may be applied, not to exceed $25.00 per record.

Regarding Payment:

- We accept the following forms of payment: Cash, Check, and all major credit cards.
- Care Credit is another form of payment we accept.
    - Care Credit is a flexible payment plan with interest free options. Care Credit does require a credit check and financing approval.
- On the day of service, we will collect from the patient their estimated patient portion as well as any deductible and coinsurance. We provide patients a detailed treatment plan that explains the sequence of their treatment and shows the estimated patient portion due at each appointment time. If the final insurance payment differs from the estimated patient portion given on a treatment estimate, the patient is responsible for the difference in full.
- Post-dated checks are not accepted as payment options.

Outstanding Balance Policy:
It is our office policy that all past due accounts be sent three statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and the patient may be discharged from the practice.
In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Returned Checks:

- The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Refunds:

- If it ever occurs where the patient makes an overpayment on their account, Family Dentistry of Sioux Falls will issue a refund to that patient within 30 business days.

Minors
The parent(s) or guardian(s) are responsible for full payment on their child's account. We encourage parent(s) or guardian(s) to bring their children to their dental appointments and remain in the office during the appointment. If a parent or guardian is not present, the child is sent with someone other than the parent or guardian, or a minor is unaccompanied, we require a signed copy of the child's proposed treatment plan by the parent or guardian before treatment can be completed for that child. For dental cleaning appointments, we ask parents to fill out and sign a Children's Dental and Medical History Update form.

Please indicate your understanding and acceptance of these policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Signature: _____

Date: _____

Family Dentistry of Sioux Falls 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 INOFRMATION. 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 unsecure protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect on March 1st, 2011 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 or 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 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 YOUR PERSONAL HEALTH INFORMATION (PHI)

*****Personal Health Information will be replaced with PHI throughout the contents of this document*****

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 you 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, include disclosure to:

- Prevent or control disease, injury, or disability;
- Report child abuse or neglect; Report elderly 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 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 U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPPA.

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 purposed as permitted by HIPPA, 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 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 funereal 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 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 suing 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 requirement of applicable law.

Disclosure Accounting. With the exception of certain disclosure, you have the right to receive and accounting of disclosure of your health information in accordance with applicable laws and regulations. To request an accounting of disclosure 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 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 pertain 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 Communications. 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: Dr. Kari Bolen DDS. Questions can be directed to our Office Manager.

Telephone: 605-339-0219 Fax: 605-339-0180

Address: Family Dentistry of Sioux Falls, 2701 S. Minnesota Ave, Ste 3

Signature _____ **Date** _____