NEW PATIENT FORM

HARDIN VALLEY
FAMILY DENTISTRY

About You

Patient Name:_____ Today's Date:_____/_____/_____
Last First MI

What you prefer to be called:_____Birthdate:____/____/____ Age:____

SS #:_____

Mailing Address:_____

_____
City State Zip

Home Phone #:(_____)_____ Work Phone #:(_____)_____Ext:_____

Cell Phone #:(_____)_____ E-mail Address:_____

Referred By:_____

Employer:_____

Employer's Address:_____

_____
City State Zip

Occupation:_____

Status: ❏ Minor ❏ Single ❏ Married ❏ Divorced ❏ Separated ❏ Widowed

Spouse's Name:_____

Account Info

Person ultimately responsible for account

❏ Same as patient information above

Name:_____

Relation:_____

Billing Address *(if different than above)*:

_____

_____
City State Zip

SS #:_____

Work Phone #:(_____)_____

Payment Method: ❏ Cash ❏ Check ❏ Credit Card

Initials_____ *I hereby authorize assignment of my insurance services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).*

Insurance

Subscriber Name: _____

Date of Birth:_____

SS Subscriber#: _____

Group#: _____

Employer:_____

ALSO, PLEASE BRING YOUR INSURANCE CARD TO BE PHOTOCOPIED.

In Event of Emergency

Whom should we contact?_____

Relation:_____

Home Phone #:(_____)_____

Work Phone #:(_____)_____

Cell Phone #:(_____)_____

Who is your medical doctor?_____

Medical Doctor's Phone #:(_____)_____

Please continue on back →

Dental Information

Reason for today's visit:_____

Are you in pain? ❑ Yes ❑ No How Long?_____

Are you happy with your smile? ❑ Yes ❑ No Explain:_____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't Know

Last Dental Exam:_____/_____/_____ Last Dental X-rays:_____/_____/_____

Medical History

Please list all medications you are taking:_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?
Please place a check mark beside all that apply:

❑ Heart Attack/Stroke	❑ Heart Surg./Pacemaker	❑ Heart Murmur	❑ Rheumatic Fever
❑ Mitral Valve Prolapse	❑ Artificial Valves	❑ Heart Disease	❑ Congenital Heart Defect
❑ Chest Pains	❑ Scarlet Fever	❑ Nervousness	❑ Thyroid Problems
❑ Kidney Problems	❑ Liver Problems	❑ Respiratory Problems	❑ Sinus Problems
❑ Stomach Problems/Ulcers	❑ Psychiatric Problems	❑ Venereal Disease	❑ Alcohol/Drug Abuse
❑ Tuberculosis TB	❑ Jaw Problems TMJ/TMD	❑ Cancer/Tumors	❑ Shingles
❑ Hepatitis	❑ HIV+/Aids/ARC	❑ Arthritis/Rheumatism	❑ Artificial Bones/Joints
❑ Emphysema	❑ Fainting/Seizures/Epilepsy	❑ Severe/Frequent Headaches	❑ Frequent Neck Pain
❑ Back Problems	❑ Cosmetic Surgery	❑ Xray or Cobalt Treatment	❑ Chemotherapy
❑ Asthma	❑ Difficulty Breathing	❑ Diabetes/Hypoglycemia	❑ Leukemia
❑ Anemia	❑ High/Low Blood Pressure	❑ Bleeding Problems	❑ Glaucoma

Please list any other surgeries or medical conditions you have or ever had:_____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Aspirin
❑ Dental Anesthetics ❑ Others:_____

Do you use tobacco? ❑ No ❑ Yes/How used?_____ How much?_____ How long?_____

For women: Are you pregnant? ❑ No ❑ Yes/How long?_____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____Date_____/_____/_____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(Office Use)

_____ ____/____/____
Initials Date
_____
Comments

_____ ____/____/____
Initials Date
_____
Comments

_____ ____/____/____
Initials Date
_____
Comments

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you 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 are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Rebecca Tucker
Phone number:(865) 692-2002
Fax number: (865) 692-2046

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on: 04/11/2019