Broad Ripple Dental Arts

PLEASE PRINT

Patient Info:

Name: _____ Preferred Name: _____
Birthdate: _____ Social Security Number: _____
Male: _____ Female: _____Child: _____ Single: _____ Divorced: _____ Married: _____
Address: _____ City: _____
State, Zip: _____ Employer: _____
Cell#: _____Work#: _____
Home#: _____ Email: _____
Where can we contact you between the hours of 8-5? _____
How did you hear about our office?_____
Is anyone in your household a current patient at our office? YES NO
Name: _____
Emergency Contact Phone: _____
Emergency Contact Name/Relationship to you:_____

Responsible Party Info:

Name: _____ Birthdate: _____
Address: _____ City: _____
State, Zip: _____ Best Phone #:_____
Insurance Primary: ***(Present your Insurance Card and Photo ID to Front Desk.)***
Insured Name: _____ Insured Date of Birth:_____
Relationship to patient: _____ Insured Social Security Number: _____
Insurance Company Name: _____ Insurance ID#: _____
Place of Employment of the insured: _____
Phone number for insured's employer: _____

Previous Dentist Name & Address: _____
Last Visit: _____ How would you rate your smile 1-10? _____
What would you change about your smile? _____

Medical History:

Name of physician: _____ Phone#: _____
Last visit with Physician: _____ Address: _____
Do you smoke? YES NO Do you use chewing tobacco: YES NO

Do you vape? YES NO Do you use a juul? YES NO

Do you or have you ever been told you snore? YES NO

Are you currently taking prescription or non-prescription medication? : YES NO

If yes, please list: _____

_____
_____
_____

Have you ever had, or been treated for any of the following: ***CIRCLE ALL THAT APPLY***

Psychiatric Problems	Tuberculosis	Heart Attack	Stroke	Hepatitis	Epilepsy
Cancer	Aids/HIV	Heart Murmur	Anemia	Kidney problems	
High Blood Pressure	Diabetes	Abnormal Bleeding	Drug Alcohol abuse	Artificial Joints	

Have you been treated for any other illness not listed? YES NO
If yes, please explain further: _____
_____

Have you been instructed by your physician to take a pre-medication (antibiotic) before dental appointments? (For medical conditions such as, artificial joint, heart problems, etc.) YES NO
If yes, what antibiotic des your physician require you to take: _____
Do you take medication that are Bisphosphates/ or medication for osteoporosis? _____
Would you be interested in receiving information about medication we can give you before a procedure to relax you or make your anxiety less severe? ***(Some do require a driver)*** YES NO
Allergies: **(Circle all that apply)** Penicillin Aspirin Codeine Erythromycin
Latex Sulfa Dental Anesthetic
Please list other allergies: _____
Women only:
Are you pregnant? YES No Due Date: _____
Are you nursing at this time? _____
Are you taking any hormone replacement therapy?_____

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 the doctor to make a through diagnosis for my dental needs.
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 use all anesthetics, sedatives and other medications as the doctor deems necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete copy of any possible complications
4. I agree to be responsible for payment of all services rendered on mine or my dependents behalf. I understand payment is due upon time of service. I understand if insurance has not paid within 90 days, the balance is my responsibility. I understand interest and a late fee cold be assessed to any outstanding balance on my account. I also agree that should it be needed, I will be responsible for any and all collection costs, which may include but are not limited to attorney fees, collection costs and court costs.
5. I understand that a 48 hour notice must be given to cancel or reschedule an appointment. I realize that a $30.00 fee may be assessed to my account if I fail to give proper notice. I realize that the doctor has the right to refuse to save time for me again in the schedule if I fail to give a 48 hour notice. If more than 3 appointments are missed or reschedule on short notice the doctor reserves the right to dismiss you as a patient from this office. If this does happen your records will be sent to another dentist of your choice.
6. I also give permission for the doctor or his staff to use any photos they may take for lecturing, education or promotional purposes.
7. PLEASE UNDERSTAND THAT YOU ARE RESPONSIBLE FOR KNOWING AND UNDERSTANDING YOUR INSURANCE LIMITATIONS AND BENEFITS.

Printed Name of Patient: _____ Date: _____

Signature: _____

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 September 1st, 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 INFORMATI ON 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Patient's Printed Name

_____

Signature of person completing this form (and relationship to patient)

Date: _____

_____

Name of person's/or entities who are allowed to inquire about patients treatment. **(PLEASE PRINT)**

_____

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: _____