DAVIES DENTAL

Patient Registration

Patient's Name _____ **Preferred Name**_____ **Single ☐ Married ☐ Child ☐**

Social Security Number (if adult)_____ **Date of Birth**_____

Address_____ **City**_____**State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____ **E-Mail**_____

Name of Spouse or Parent's Name (if minor)_____

Patient (or Guardian) Employed by_____ **Phone**_____

Who holds financial responsibility for this patient?:_____**Social**_____

Address and phone # if different from Patient:_____

_____

In case of an Emergency, who should be notified_____ **Phone**_____

Do you have dental insurance that may cover any part of our professional services_____ **Yes ☐ No☐**

If so, primary policy holders name_____**Relationship to Patient**_____

Name of primary company_____ **Phone #** _____**ID#**_____

Social Security # of Policy Holder (if not above)_____ **Date of Birth of Policy Holder**_____

Policy Holder Employed By (if covered by spouse insurance)_____

Do you have secondary dental insurance _____**Yes ☐ No☐**

If so, primary policy holders name_____**Relationship to Patient**_____

If so, name of secondary company_____ **Phone #**_____ **ID#**_____

Social Security # of Policy Holder (if not above)_____ **Date of Birth of Policy Holder**_____

Policy Holder Employed By (if covered by spouse insurance)_____

How did you hear about us?

☐Current Patient-whom may we thank? _____

☐ Internet/Facebook ☐ Insurance ☐Other_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Davies Dental, LLC to release health information including but not limited to: HIV, AIDS, information about substance abuse treatment, mental health services, pre-medication information, under the following terms 1) obtain insurance benefit information 2) refer you to a specialist 3) speak with a specialist 4) phone in prescriptions. You are under no obligation to authorize disclosure. If you sign this authorization, you may revoke it at any time with written notice.
I UNDERSTAND THE AUTHORIZATION TO RELEASE HEALTH INFORMATION. I AM SIGNING THIS VOLUNTARILY. I AUTHORIZE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED.

Signature of Responsible Party_____ **Date**_____

DAVIES DENTAL

Patient Responsibility Agreement

Patient Printed Name_____Date_____

Responsible Party Printed Name_____

In consideration of treatment rendered, I accept full financial responsibility.
We accept Cash, Checks, Visa, MasterCard, Discover, American Express, and Care Credit.

Regarding Insurance
Payment is due at the time of service. If you have dental insurance, we accept assignment of insurance benefits after co-payments and deductibles are met. Regardless of payment by your insurance, payment is due in full within 30 days of service. Your insurance is a contract between you and your insurance company and their payments should be monitored by you for timely payment. If you do not have dental insurance, our office will extend a 10% discount on services rendered that are paid in full at the time of the initial appointment. Any payment arrangements must be made prior to treatment.

Missed Appointments
In consideration of our patient's schedules, we ask that you choose an appointment time you will be able to keep. We understand that emergency situations arise occasionally and will take that into consideration. We ask that you provide our office with a 48 business hour cancellation notice. In the event of a failed or canceled appointment without 48 business hour notice, our office will assess a fee of $35.00.

Monthly Billing Fees
I understand that monthly statements will be forwarded to me for the fees in which I am responsible including a $5.00 monthly billing fee for balances over 30 days. All payments are due as indicated on the statement. Any payment made after the due date are considered late and will accrue additional billing fees monthly. All delinquent accounts will be forwarded for collections. Any refiling fees, collection charges, court costs, and reasonable attorney fees will be added to an overdue balance.

NSF Fees
I I agree to pay a fee of $35.00 for all NSF checks returned to our office.

Photos
Occasionally Davies Dental, LLC will take photos of our patients to display, use on our social media sites, or in printed material to promote our practice. I do not expect compensation, financial or otherwise, for the use of these photos. Please initial one of the following statements:

_____I agree to allow my photo or my child's photo to be displayed by Davies Dental, LLC
____I do not allow my photo or my child's photo to be displayed by Davies Dental, LLC

Consent for treatment
The undersigned hereby authorizes any doctors employed by Davies Dental, LLC or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a comprehensive diagnosis of existing conditions. I further authorize any doctors employed by Davies Dental, LLC or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I also assign all insurance benefits to Davies Dental, LLC

Authorization to Release Health Information
I authorize Davies Dental, LLC to release health information including but not limited to: HIV, Aids, information about substance abuse treatment, mental health services, pre-medication information, images under the following terms 1) obtain insurance benefit information 2) refer you to a specialist 3) speak with a specialist 4) phone in prescriptions. You are under no obligation to authorize disclosure. If you sign this authorization, you may revoke it at any time with written notice. Please note that our HIPAA policy is available for your review upon request.
I have read and understand the financial statement above, and agree to accept financial responsibility as described. I agree and assign any/all insurance benefits to be paid directly to Davies Dental, LLC
I have also read and understand the consent for treatment as described above, and agree to be bound as described.

Signature of Responsible Party_____

Dental History

Name_____

Please check any of the following problems that apply to you.

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, earaches, neck pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following:

- ☐ Dentures
- ☐ Partial Denture
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

- ☐ Your last cleaning____/_____
- ☐ Your last oral cancer screening_____/_____
- ☐ Your last complete x-rays____/_____

Name of Previous Dentist:

_____

City:_____State:_____

Phone:_____

Why did you leave your previous dentist?

_____

_____

Are you interested in whiter teeth?

☐ Yes ☐ No ☐ I would like more information.

Do you smoke or use chewing tobacco?

☐ Yes How Much_____

How Long_____

☐ No

If you could change your smile, you would:

- ☐ Make it brighter
- ☐ Make it straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale of 1-10 with 10 being the highest:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit?

_____

_____

Patient Name:

Birth Date:

DAVIES DENTAL
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, c

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

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 of Patient, Parent or Guardian:

X Date:_____

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Deana McClimon

Telephone: 317-288-5388 Fax: 317-288-5412

E-Mail: deana@davies-dental.com

Address: 9850 E. 79th Street, Indianapolis, IN 46256

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
Date

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____