1 Patient Information

Date_____

Name_____
Last First

Address_____

City_____ State_____ Zip_____

E-mail_____

Home Phone_____ Cell_____

Sex ☐ M ☐ F Birth date_____ Age_____

☐ Married ☐ Single ☐ Widowed ☐ Minor

Patient's Employer (or parents name) _____

Work Phone _____ SSN_____

Address_____

City_____ State_____

Zip Code_____

RESPONSIBLE PARTY

Name_____ Relationship_____

Address _____

City_____ State_____ Zip_____

EMERGENCY CONTACT

Name_____

Relationship_____ Phone_____

Who may we thank for referring you?

Name_____

Patient Qwest Yellow Pages Yellow Book Mailing

Insurance Company Another Doctor

2 Dental Insurance

Name of Insured_____

Employer_____

Employer Phone_____

Insurance Company_____

Insurance Address_____

City_____ State_____ Zip_____

Insurance Phone_____

Relationship to Patient_____

Birthdate_____ Social Security#_____

Subscriber ID#_____ Group #_____

Please fill out if you know your policy benefits:

% Of: Preventative_____ Basic_____ Major_____

Fiscal Year Date_____ Annual Deductible_____

Annual Maximum_____ Amount Remaining_____

Limits: Cleanings_____ Fluoride_____ X-rays_____

ASSIGNMENT & RELEASE:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Silverstone Family Dental all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Silverstone Family Dental To release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions. X_____Date_____

3 Office Policy

I understand the responsibility for payment for dental services provided in this office for my dependents or me is mine, due and payable at the time services are rendered. I further understand that a **1 ½ %** finance charge per month (18% annually) will be added to any balance over 60 days. In the event of default, I/we promise to pay legal interest on the indebtedness, together with collections costs and attorney fees as consent to a credit check based on that information. I agree to be, and hereby am fully responsible for total payment and of the charges for procedures performed in this office, including any amounts not covered by any dental insurance or prepayment plan that I/my spouse may have. **Cancellation** without a 48- hour notice **or Failure to show** for a scheduled appointment will result in a **$50.00 per scheduled hour** charge.

Signed Date

4 Dental History

Who was your previous Dentist? _____When were your last X-rays? _____Cleaning? _____Exam? _____

Please **circle** to indicate if you **Do or have had** any of the following:

Pain/Discomfort	History of Periodontal Disease	Loose/Broken Teeth	Use Tobacco Products _____Per day
Bad Breath	Difficult Extractions	Loose fillings	Recreational Drugs/Drug Addiction
Bleeding Gums	Jaw Problems	Lip/Cheek Biting	Excessive Soda/Juice consumption
Sores on Lips/Gums	Clenching/Grinding	Thumb/finger sucking	Excessive Sweets/Candies
Lumps in/near mouth	Dry Mouth	Full/partial Denture	Bad Experience in Dental Office
History of Gum Disease	Sensitivity	Retainer	Do you like your smile? _____

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of last physical exam_____
Are you under medical treatment now?_____ Have you been in the last 2 years?_____
Have you ever been hospitalized for any surgery or serious illness?_____
Do you have or have you had any of the following conditions? Please check all that apply.

☐ Heart Attack/Surgery	☐ Hepatitis/Jaundice	☐ Arthritis
☐ Heart Murmur	☐ Kidney Disease	☐ Glaucoma
☐ Heart disease/Pacemaker	☐ Diabetes	☐ Fainting
☐ Chest Pains	☐ Thyroid Problems	☐ Epilepsy/Convulsions
☐ High/Low Blood Pressure	☐ Stomach Problems	☐ HIV Infection/Aids
☐ Rheumatic Fever	☐ Leukemia/Anemia/blood disorder	☐ Herpes Simplex I or II
☐ Stroke	☐ Cancer	☐ Drug addiction
☐ Asthma/Respiratory	☐ Radiation/Chemotherapy	☐ I have taken Fen-Phen
☐ Hay Fever/Allergies	☐ Osteoporosis Treatment	☐ Do you wear contacts
☐ Full/partial joint replacement	☐ Other_____	

Do you snore or have you been told you snore? _____
Have you had a sleep study or been told to get one? _____
Do you wear a CPAP or have been told you need one? _____

Please list any disease, condition or problem not listed_____

Women only:
Are you pregnant?_____ Are you taking birth control?_____
ARE you aware that antibiotics can decrease the effectiveness of birth control?_____

MEDICATIONS

Please list medications you are currently taking:

_____
_____
_____
____Not currently taking meds
Pharmacy Name:_____

ALLERGIES

Have you had reaction to any of the following?
(please check if yes)

Aspirin/Ibuprofen____	Penicillin____
Codeine____	Sedatives____
Iodine____	Sulfa____
Latex____	Local Anesthetic____
No known drug allergies____	Other_____

Signature I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information may be detrimental to my health.

_____ _____ _____
Patient Parent or Guardian Date

SILVERSTONE FAMILY DENTAL OFFICE

2026 S. Eagle Rd. Meridian. ID 83642

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date	Initials	Reason

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 **April 14, 2003**, 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 SERVICE: 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 you 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. NA for each page, $0. NA per hour for staff time to locate and 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 purposed, other than treatment, payment, healthcare operations and certain other activities, for the last six 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 healthcare 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 you 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: **Silverstone Family Dental Privacy Officer**
Telephone: **208-888-3623**
Fax: **208-888-9712**
Address: **2026 S. Eagle Rd., Meridian, ID 83642**