

Patient registration form

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____

Preferred Phone #: _____ Is this a mobile number? Yes No

Email Address: _____

Date of Birth: _____ Sex: Male Female Unspecified

Emergency Contact: _____ Emergency Phone #: _____

RESPONSIBLE PARTY (if different than patient)

First Name: _____ Middle Name: _____ Last Name: _____

Street: _____ Zip: _____ City: _____ State: _____

Date of Birth: _____ Sex: Male Female Unspecified

Responsible Party Signature: _____ Date: _____

PRIMARY DENTAL INSURANCE

Is subscriber the same as patient? Yes No

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Subscriber SSN: _____

Employer Name: _____ Insurance Company: _____

Insurance Phone Number: _____

Subscriber ID/Policy Number: _____ Group/Contract Number: _____

Relationship to Subscriber: Child Disabled Dependent Self Spouse Other Dependent

How did you hear about us? _____

PATIENT NAME _____ Birth Date _____

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. Thank you for answering the following questions.

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

Women: Are you _____

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: _____

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

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

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 _____ DATE _____

financial policy

Pleasant Valley Dentistry strives to offer convenient payment options. At the onset of treatment, your dentist will provide you with a comprehensive treatment plan based on your overall health. You will also receive a clear, detailed estimate of the cost of your plan, including your estimated insurance benefits. If you have questions regarding coverage through your insurance plan, please contact your insurance company directly.

Please understand that initial treatment plans include *estimated* costs. During the course of treatment, plans may change. At times, plans may change based on unobservable complications, initial procedure outcomes, or patient desire. Be assured that our top priority is your dental health, and we will always do our best to provide the highest quality of treatment available.

Please take a moment to review the financial options offered and indicate your choice of payment:

- Plan A. Payment in full on the day of each visit via Check, Cash, or Credit Card. To demonstrate our appreciation for patients who pay in full at the time of treatment, we will extend a 5% reduction of the treatment fee.
- Plan B. We are pleased to offer our patients a one-year interest free line of credit through Wells Fargo Financial. We would be happy to help you with the application process; it is quick & easy.
- Plan C. Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your estimated co-payment is due in full on the day of treatment. Please note, you are responsible for any fees not covered by your insurance. Also remember that dental insurance plans are not designed to cover all your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the quality of plan selected and purchased by your employer.

Statement: Based on the selection above, I accept full financial responsibility for this account and for all dentistry performed upon my dependents in this office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. Balances older than thirty days will be subject to a monthly finance charge with an annual percentage rate of 18%.

Please note, when you find yourself unable to keep the appointed time that you have reserved with dentist and his staffs' schedule, we ask that you inform us as soon as possible. A minimum of 24 hours-notice is required to avoid a \$52.00 fee for a broken appointment.

Responsible Party Signature: _____ Date: _____

privacy policy

Our Legal Duty

Pleasant Valley Dentistry, like all other medical and dental practices, is 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. 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 according to the means outlined in this notice.

Uses and Disclosures of Health Information

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

We may use or disclose your health information to a physician/dentist, dental auxiliaries, students and other healthcare providers providing treatment to you.

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

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 performances, conducting training programs, accreditation, certification, licensing or credentialing activities.

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. This includes family members, friends, care-givers, or anyone you prefer to be involved with your healthcare. 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.

We may use Patient Information internally to offer goods and services we believe may be of interest. We may use Patient Information to contact you to inquire or survey about the Patient experience during your visit and the prospect of future services or improvements needed to continue as your services provider. We may also create and use aggregate Patient Information that is not personally identifiable to understand more about the common traits and interests of our Patients.

We may utilize one or more third-party service providers to send email or other communications to you on our behalf, including Patient satisfaction surveys. These service providers are prohibited from using your email address or other contact information for any purpose other than to send communications on our behalf.

It is our intention to only send email communications that would be useful to you and that you want to receive. When you provide us with your email address as part of the registration or appointment setting process, we will place you on our list of patients to receive informational and promotional emails.

Each time you receive a promotional email, you will be provided the choice to “opt-out” of future emails by following the instructions provided in the email, or you can “opt-out” at any time by following the instructions provided.

We will not use your health information for fundraising activities without your written consent.

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

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.

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 a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

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

Patient Rights

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. We may charge a fee for producing dental records and X-rays as allowed by law.

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. 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.

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). When you pay in full outside of your insurance plan for services you may request that we restrict this information and not disclose it to your healthcare plan or insurer.

We will provide you with notification of a breach of unsecured PHI as required by law.

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be 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. You have the right to request that we amend your

health information. This request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

If you received this notice on our web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

Questions and Concerns

If you would like additional information about our privacy practices or have questions, please ask our administrative assistant or any team member.

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 our handling of your 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, you may send your concerns to Pleasant Valley Dentistry, Attn: HIPAA Compliance Officer, 3878 Middle Rd, Bettendorf, IA, 52722. You also may submit written concerns to the U.S. Department of Health and Human Services. We will provide you with the address to the U.S. Department of Health and Human Services upon request.

We support your right to maintain 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.

Consent for Treatment (signed by ALL new patients)

I certify that I have read and understand the included questions and acknowledge that questions have been answered to the best of knowledge. I hereby give my consent to the dentist to perform an examination and diagnose my condition. I also give my consent for any preventive or basic restorative procedures which may be necessary. I understand that this consent will remain in effect until treatment is terminated either by me or the dentist.

Patient or
Responsible Party Signature: _____ Date: _____

Notice of Privacy Practices (signed by ALL new patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Patient or
Responsible Party Signature: _____ Date: _____

Release of information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance)

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Responsible Party Signature: _____ Date: _____

Authorization for Release of Health Records to External Parties (Optional)

I authorize the disclosure of information from my treatment records to:

Name of Recipient: _____

Relationship to the Patient: _____

Patient or
Responsible Party Signature: _____ Date: _____