Original Date:
Dates Revised:

RICHLAND DENTAL CENTER
PATIENT REGISTRATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT INFORMATION	
Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Address:	
City:	**State, Zip Code:**
Home Phone:	**Work Phone:**
Cell Phone:	**How did you hear about us?**
Email:	**I would like to receive email correspondences:** ☐ Yes ☐ No
Social Security:	**Driving License number:**
Emergency contact name:	**Emergency contact number:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last dental exam:**
PRIMARY INSURANCE INFORMATION	
Name of Insured:	**Relationship to patient:**
Insured's Employer:	**Employer Phone:**
Insurance ID #:	**Insurance Group #:**
Insurance Company:	**Insurance Phone:**
SECONDARY INSURANCE INFORMATION	
Name of Insured:	**Relationship to patient:**
Insured's Employer:	**Employer Phone:**
Insurance ID #:	**Insurance Group #:**
Insurance Company:	**Insurance Phone:**
Please carefully read below:	
I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PAITENTS DETERMINED NEEDS. I ALSO AUTHORIZE RICHLAND DENTAL TO PERFORM ANY AND ALLFORMS OF TREATMENTS, MEDCIATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMOBIDIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND RICHLAND DENTAL, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO RICHLAND DENTAL. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").	
Patient Signature:	**Date:**
Parent/Guardian Signature:	**Date:**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESSCRIBES 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 & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identified health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This ACT gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuses personal health information.
As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent form, we may use and disclose your medical records only for each of the following purpose: treatment, payment and health operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirm coverage, billing and collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operation include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to identifiable information. We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency situations, if we attempt to obtain such consent so soon as reasonably practicable after the delivery of such treatment;
- If we required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgement, your consents to receive treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your written authorization. You may revote such authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are however, not disclosure to agree to requested restriction. If we do agree to a restriction, we must abide to it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the notice of Privacy practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protection have been violated. You have the right to file a formal, written complaint with us at the address below, or with Department of Health & Human services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

☐ I do NOT authorize any information to be discussed with any family members or friends.

☐ I authorize information about treatment of appointments to be discussed with following person(s):

Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
Name:	**DOB:**
I have read and understand the above information	
Patient/parent/Guardian Name (printed):	**Date:**
Patient/parent/Guardian Signature:	**Date:**

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?	☐ Yes	☐ No
If yes, for what?		
Doctor Name:		
Address:		
City:	**State, Zip Code:**	
2. Have you taken any medication or drugs during the past two years?	☐ Yes	☐ No
If yes, for what?		
3. Are you taking any medication, drugs or pills now?	☐ Yes	☐ No
If yes, please answer below.		

Name the Drug	Strength	Frequency Taken

4. Have you ever taken prescription medications for weight loss (diet pills)?	☐ Yes	☐ No
If yes, what type?		
5. Are you aware of having allergies (or adverse) reaction to any medication or substance?	☐ Yes	☐ No
If yes, please list below:		

Allergies to medications

Name the Drug	Reaction You Had

Allergies to substances

Name the Substance	Reaction You Had

6. Have you been a patient in the hospital during the past five years?	☐ Yes	☐ No
If yes, please answer below:		

Name the Hospital	Date	Reason

7. Indicate which of the following you have had, or have at present. Please check **tick** mark (✓) or **cross** (X) on each item, answer L to R, up down.		
☐ Chest Pain	☐ Congenital heart Disease	☐ Heart Murmur
☐ High Blood Pressure	☐ Mitral Valve prolapse	☐ Artificial Heart Valve
☐ Heart Pacemaker	☐ Rheumatic Fever	☐ Arthritis/Rheumatism
☐ Cortisone Medicine	☐ Swollen Ankles	☐ Stroke
☐ Diet (Special/Restriction)	☐ Artificial joints (hip, knee)	☐ Kidney Trouble
☐ Hepatitis (A/B/C)	☐ A.I.D.S	☐ Cold Sores/Fever Blisters
☐ Hemophilia	☐ Bruise Easily	☐ Yellow Jaundice
☐ Epilepsy or Seizures	☐ Ulcers	☐ Diabetes
☐ Thyroid Problems	☐ Glaucoma	☐ Contact Lenses
☐ Emphysema	☐ Chronic Cough	☐ Tuberculosis
☐ Asthma	☐ Hay Fever	☐ Latex Sensitivity
☐ Allergies or Hives	☐ Sinus Trouble	☐ Radiation Therapy
☐ Chemotherapy	☐ Venereal Diseases	☐ H.I.V Positive
☐ Sickle Cell Diseases	☐ Neurological Disorders	☐ Fainting or Dizzy Spells
☐ Psychiatric/Psychological	☐ Nervous/Anxious	☐ Other Pain Discomfort

8. Do you use more than two pillows to sleep?	☐ Yes	☐ No
9. Have you lost of gained more than 10 pounds in past year?	☐ Yes	☐ No
10. Do you have or have had any diseases, condition, or problem not listed?	☐ Yes	☐ No
If yes, please list:		
11. Women who is pregnant?	☐ Yes	☐ No
12. Women who is Nursing?	☐ Yes	☐ No
13. Taking birth control pills?	☐ Yes	☐ No

I, THE UNDERSIGNED THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF CHANGES IN MY HEALTH OR MEDICATIONS.

Patient Signature:	**Date:**
Doctor Signature:	**Date:**

RICHLAND DENTAL BILLING PROCESS

Thank you for choosing Richland Dental. In efforts to better serve you, we would like to take time to explain the billing process at our office.

Once you provide the office with your dental insurance, we call your insurance company and verify your benefits. The information we receive from your insurance company is only an estimation of coverage and not a guarantee.

After you have been in our office, we will file your claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive in the mail and be responsible for the remaining account balance.

Thank you again for choosing Richland Dental for your dental needs. We look forward to a long-lasting relationship with you.

I have read and understand the billing process at Richland Dental Center.

Patient/parent/Guardian Name (printed):	**Date:**
Patient/parent/Guardian Signature:	**Date:**

RICHLAND DENTAL POLICIES

Initial Below

_______PRACTICE POLICIES

Our goal is to provide quality dental care in timely manner. In order to do so we have had to implement a Cancellation and no-show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

_______CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patients needs, please call our office promptly if you are unable to attend an appointment. We ask that you call **24 hours** in advance to reschedule/cancel or we have the right to charge for cancellation fee. ***A no show/no call will result in a cancellation fee of $ 50.***

_______NO SHOW POLICY

A "no show" is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. ***A no show for a scheduled appointment will result in a fee for $50 <u>for every half hour scheduled.</u>***

_______LATE ARRIVALS

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. ***If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.***

_______EMERGENCY CARE

Patient are seen at their appointment times. Occasionally, we will have to accommodate a patient in discomfort or in any other emergency situation that may affect your reserved appointment time. This courtesy is extended to you and all patients and we ask for your understanding when these unexpected situations arise. Out of respect for your time, we will keep you informed of such times. We thank you in advance.

I have read and understand the "Practice Policies"

Patient/parent/Guardian Name (printed):	**Date:**
Patient/parent/Guardian Signature:	**Date:**