Newhart Dental
Center for Advanced Dentistry

NEW PATIENT REGISTRATION AND HEALTH HISTORY

PATIENT INFORMATION:

NAME:_____SEX:_____DOB:_____
SS#:_____
ADDRESS:_____
CITY AND ZIP CODE:_____
E-MAIL:_____
CELL #:_____

EMERGENCY INFORMATION:

EMERGENCY CONTACT: _____
RELATIONSHIP: _____
CELL #:_____

INSURANCE COVERAGE: YES / NO **IF YES, COMPLETE BELOW**

PRIMARY INSURANCE SUBSCRIBER INFORMATION:

INSURANCE CARRIER:_____
INSURED NAME:_____DOB:_____
INSURED ID# OR SS#:_____
EMPLOYER:_____
RELATIONSHIP TO PATIENT:_____
ADDRESS: _____
CELL #:_____

SECONDARY INSURANCE SUBSCRIBER INFORMATION:

INSURANCE CARRIER: _____
INSURED NAME: _____ DOB: _____
INSURED ID# OR SS#: _____
EMPLOYER: _____
RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
CELL #: _____

PRINT NAME _____ HEIGHT _____ WEIGHT _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING SYSTEMIC CONDITIONS:

Yes / No Rheumatic Fever	Yes / No Kidney problems	Yes / No Diabetes
Yes / No Rheumatic Heart Disease	Yes / No Bacterial Endocarditis	Yes / No Epilepsy/seizure
Yes / No Heart Murmur	Yes / No Heart valve prosthesis	Yes / No Prolonged bleeding
Yes / No Congenital Heart Disease	Yes / No Joint prosthesis	Yes / No Asthma
Yes / No Mitral Valve Prolapse	Yes / No Cardiac pacemaker	Yes / No Arthritis
Yes / No Systemic Lupus	Yes / No Hypertrophic Cardiomyopathy	Yes / No High Blood pressure
Yes / No Mental Disorders	Yes / No Cancer	Yes / No Anemia

INFECTION CONTROL:	ALLERGIES:	DOCTOR NOTES:
Yes / No Tuberculosis	Yes / No PCN	_____
Yes / No Hepatitis	Yes / No SULFA	_____
Yes / No Are you a carrier?	Yes / No FEN-PHAN	_____
Yes / No Cold sores / fever blisters	Yes / No LATEX	_____
Yes / No HIV positive: _____	Other: _____	_____
Yes / No AIDS: _____		_____
Yes / No Other Infections: _____		

Yes / No Have you ever had adverse reaction to anesthesia? Comment: _____

CURRENT MEDICATION: YES / NO If needed, please attach separate sheet.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

WOMEN:

Yes / No Are you pregnant?

Due Date: _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES / NO

DESCRIBE CONDITION: _____

_____

GENERAL PHYSICIAN: _____ PHONE #: _____

Have you taken any of the following bisphosphonates?:

Yes / No Alendronate (Fosamax)	Yes / No Raloxifene (Evista)	Yes / No Antibiotic premedication suggested by M.D.?
Yes / No Clodronate (Bonefos, Ostac)	Yes / No Risedronate (Actonel)	
Yes / No Etidronate (Didronel)	Yes / No Teriparatide (Forteo)	
Yes / No Ibandronate (Boniva)	Yes / No Tiludronate (Skelid)	Yes / No Antibiotic premedication used previously?
Yes / No Pamidronate (Aredia)	Yes / No Zoledronate (Zometa)	

PREMEDICATION:

If yes to any of the above, when? _____

Prescribing Doctor Name and Phone #: _____

UNDERSTAND THAT THE INFORMATION I PROVIDE ON THIS FORM IS ESSENTIAL TO DETERMINE MY DIAGNOSIS AND THE PROVISIONS OF TREATMENT. I UNDERSTAND THAT IF ANY CHANGE OCCURS IN MY HEALTH I AM TO REPORT IT TO THIS OFFICE AS SOON AS POSSIBLE. I HAVE READ AND UNDERSTAND EACH QUESTION, AND HAVE ANSWERED ALL OF THEM TRUTHFULLY AND TO THE BEST OF MY ABILITY. I HAVE DISCUSSED MY HEALTH HISTORY WITH THIS DOCTOR.

_____ DATE	_____ PATIENT SIGNATURE	_____ DATE	_____ DOCTOR SIGNATURE

Newhart Dental, Inc.
Center for Advanced Dentistry

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf of my dependents (if any).

SIGNATURE:	**DATE:**

NEWHART DENTAL
Center for Advanced Dentistry

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposed that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to Inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records, psychotherapy notes information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that part of your protected health 8information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a compliant.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer n person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

DATE: _____

PRINT NAME: _____

SIGNATURE: _____

NEWHART DENTAL

Center for Advanced Dentistry

LATE CANCELLATION / NO-SHOW

THE POLICY IS AS FOLLOWS:

HYGIENIST APPOINTMENTS for Cleaning or Periodontal Treatment:

No Show or Cancelled appointments without **48 hour notice - $50 Dollars**

DOCTOR APPOINTMENTS for Dental Treatment:

No Show or Cancelled appointments without **48 hour notice - $50 to $100 Dollars**

OUR STAFF APPRECIATES YOUR UNDERSTANDING.

THANK YOU.

I HAVE READ AND AGREED TO THE POLICY.

Patient or Responsible Party Signature **Date**