Demographics

Date: _____ **Date of Birth:** _____

Name: _____

Address: _____

Email Address: _____

Phone Number: _____

Gender listed on Insurance: _____

Social Security Number: _____

How did you hear about us? _____

Dental History

Reason for Visit: _____

Date of Last Visit: _____

How often do you floss? _____

Do you have:

☐ **Bad Breath**	☐ **Bleeding, Red, Swollen Gums**
☐ **Clicking or Popping Jaw**	☐ **Broken/Loose Teeth or Fillings**
☐ **Clenching/Grinding Teeth**	☐ **Pain around Ear/Side of Face**
☐ **Sores/Blisters in Mouth**	

List any other Dental Concerns/Pain:

_____

_____

Have you ever had trauma to the face, jaw, or teeth as a child or recently?

_____

_____

Have you ever had a bad experience at the dentist?

_____

_____

Would you like to change anything about the appearance of your teeth?

_____

_____

Insurance History

Name of Insured: _____

Insured Birth Date: _____

Insured Address/City/State/Zip: _____

Patient's Relationship to Insured: _____

Insured's Employer Name: _____

Employer's Address/City/State/Zip: _____

Carrier Name: _____

Plan Name: _____

ID #: _____

Group #: _____

Insurance Company Phone Number: _____

Insurance Address/City/State/Zip: _____

Signature of Insured: _____

Date: _____

Medical History

Do you have any allergies to the following? (Check box if yes)

☐ **Aspirin**	☐ **Local Anesthetic**
☐ **Latex**	☐ **Antibiotics** (Penicillin, Amoxicillin, Clindamycin)
☐ **Sulfa**	☐ **Opioids** (Percocet, Oxycodone, Tylenol 3)
☐ **Codeine**	

List any other allergies:

_____

_____

Do you have any of the following? (Check box if yes)

- ☐ **Abnormal (high or low) blood pressure**
- ☐ **AIDS/HIV**
- ☐ **Artificial Heart Valves**
- ☐ **Heart Problems**
- ☐ **Arthritis/Rheumatism/Gout**
- ☐ **Shortness of Breath (Breathing Problems)**
- ☐ **Artificial Joints/Bones**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Glaucoma**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Ulcer**
- ☐ **Fainting/Dizziness**
- ☐ **Hepatitis**
- ☐ **Kidney Disease**
- ☐ **Nervous Problems**
- ☐ **Sleep Apnea/Snoring Problems**
- ☐ **Congenital Heart Lesions**
- ☐ **Anemia/Bleeding/Bruising**
- ☐ **Blood Disease**
- ☐ **Pacemaker**
- ☐ **Tumor growth on head/neck**
- ☐ **Radiation Treatment (Xray/Cobalt)**
- ☐ **Asthma**
- ☐ **Chemotherapy**
- ☐ **Emphysema**
- ☐ **Sinus trouble**
- ☐ **Thyroid problems**
- ☐ **Osteoporosis**
- ☐ **Epilepsy**
- ☐ **Headaches (frequent)**
- ☐ **Herpes**
- ☐ **Liver Disease**
- ☐ **Psychiatric care**

PATIENT INTAKE PAPERWORK

List any other medical conditions that you have:

_____

_____

Are you under the care of a physician? Yes _____ No _____
If yes, please explain with contact information.

_____

_____

List any serious illnesses/surgiers/hospitalizations:

_____

_____

List any medications you are taking (including over-the-counter/vitamins/supplements):

_____

_____

Have you ever been instructed to take antibiotics before any dental work? Yes ____ No ____

Have you received all recommended childhood vaccinations? Yes ____ No ____

Date of your last tetanus shot? _____

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No

High sugar intake? ☐ Yes ☐ No

Pregnant? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

Have you had a positive test for Covid-19? ☐ Yes ☐ No

Patient name printed: _____

Signature of Patient/Guardian: _____

Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient, and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of thirty (30) days from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

I understand the above information and agree with its content.

Signature: _____ **Date: _____**

HIPPA Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Neighborhood Dental Studio to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtainment of payment from third party payers (i.e. my insurance company);
- The day to day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information and my rights under HIPAA. I understand that the office reserves the right to change the terms of this notice from time to time, and that patients may contact us at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Neighborhood Dental Studio is not required to agree to these requested restrictions. However, if Neighborhood Dental Studio does agree in writing, then the practice is bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of Patient/Guardian: _____

Patient name (printed): _____

Date: _____

Is there another individual to whom you would like to release medical records, financial information and treatment plans?

Name: _____ **Relationship to Patient: _____**

Name: _____ **Relationship to Patient: _____**

Notice of Privacy Policy

**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 Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a Notice of Privacy policy.

The privacy practices described are currently 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 law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the office manager.

USES AND DISCLOSURE OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

- **Treatment services:** We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you.
- **Payment and Health Care Operations:** We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out-of-pocket.
- **Marketing/Fundraising:** We will not use your health information for marketing or fundraising purposes without your consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.
- **Legal Requirements:** We may use or disclose your health information when required to do so by law.
- **Abuse or Neglect:** If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.
- **National Security:** When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required

for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.

- **Family Members, Friends, and Others Involved in Care:** At your request, we may disclose your health information to a family member or other person, if necessary, to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA, we may disclose your information to these persons in the event of an emergency situation. We may also make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition or death.
- **Business Associates:** Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.
- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Research:** We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.
- **Public Health Activities:** We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability; to report reactions with medications or problems with products, to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease or condition; to notify the proper government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (when required by law).
- **Other Authorizations:** 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 authorization, you may revoke it at any time. Your revocation will not affect any use or disclosure 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.
- **Breach Notification:** We will notify you any time your personal health information may have been compromised through unauthorized acquisition, use or disclosure.

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. We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the office manager.
- **Accounting of Disclosures:** 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. 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 will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be 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 locations, and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.
- **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please ask for the office manager of the practice. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you may contact us at info@neighborhooddentalstudio.com. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address 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 HHS.