

CONFIDENTIAL PATIENT INFORMATION FORM

(Mr.,Mrs.,Ms.,Dr.)First Name: _____ Preferred _____ M.I.: _____ Last Name: _____

Sex: M F Date of Birth: _____ Age: _____ Social Security No.: _____

Street: _____

City: _____ State: _____ Zip: _____

Home #: (_____) _____ Bus. #: (_____) _____ Cell #: (_____) _____

E-mail Address: _____

Physician's Name: _____ Physician's #: (_____) _____

Whom may we thank for referring you? Patient _____ Internet Direct Mailer Phone book
 New Mover Letter Signage Other _____

Marital Status: Married Divorced Legally Separated Widow Single

Who will be responsible for your account? Self Spouse Mother Father Other: _____

Name: _____ Home #: (_____) _____

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

Employer: _____ Bus. #: (_____) _____

Social Security No: _____ Date of Birth: _____

DENTAL INSURANCE COMPANY (PRIMARY):

Name: _____

Address: _____

Phone: (_____) _____

Group No: _____

DENTAL INSURANCE COMPANY (SECONDARY):

Name: _____

Address: _____

Phone: (_____) _____

Group No: _____

INSURED PARTY:

Name: _____

Relation to Patient: Self Spouse Parent Other

Date of Birth: _____ Social Security No: _____

Street: _____

City, State, Zip: _____

Phone: (_____) _____

Employer: _____

INSURED PARTY:

Name: _____

Relation to Patient: Self Spouse Parent Other

Date of Birth: _____ Social Security No: _____

Street: _____

City, State, Zip: _____

Phone: (_____) _____

Employer: _____

Patient/Parent or Legal Guardian Signature: _____ **Date:** _____

I have received a copy of Hawk Ridge Dental Care's Financial Policy. _____
Patient/Parent or Legal Guardian Signature

I have received a copy the Notice of Privacy Practices. _____
Patient/Parent or Legal Guardian Signature

MEDICAL HISTORY FORM

To Our Patients:

Your health is of the utmost importance to us. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Name _____ Date: _____

Height _____ Weight _____ Are you in good health? Y N _____

Are you under the care of a physician? Y N If so, what are you being treated for? _____

MEDICATIONS

Are you taking any kind of medicine, drug, or pills for any purpose?..... Y N

Anitcoagulants (Blood Thinners)?..... Y N

Tranquilizers?..... Y N

Cortisone?..... Y N

Bisphosphonates?..... Y N

Antibiotics—Currently taking? Y N If yes, which one? _____

Other Medications (Please list with dosage and purpose)

ALLERGIES

Are you allergic to or had a reaction to:

Local anesthetics?..... Y N

Latex?..... Y N

Penicillin?..... Y N

Other antibiotics? Please specify..... Y N

Sulfa Drugs?..... Y N

Barbiturates, Sedatives, or Sleeping Pills?..... Y N

Aspirin?..... Y N

Iodine?..... Y N

Codeine or Other Narcotics?..... Y N

Other Medications?..... Y N

Allergies Other than Drug Allergies? (Please list) _____

WOMEN

Is there a possibility that you may be pregnant?..... Y N

Estimated delivery date?..... Y N

Are you nursing?..... Y N

Are you taking birth control pills?..... Y N

HAVE YOU HAD OR DO YOU HAVE...

1. Rheumatic Fever?..... Y N
2. Damaged Heart Valve/
Mitral Valve Prolapse?..... Y N
3. Heart Murmur?..... Y N
4. Irregular Heart Beat?..... Y N
5. Chest Pain/Angina?..... Y N
6. Heart Attack(s)?..... Y N
7. Cardiac Pacemaker?..... Y N
8. High Blood Pressure?..... Y N
9. Low Blood Pressure?..... Y N
10. Heart Surgery?..... Y N
11. Bronchitis/Chronic Cough?..... Y N
12. Asthma?..... Y N
13. Hay Fever/Sinus Problems?..... Y N
14. Tuberculosis?..... Y N
15. Emphysema?..... Y N
16. Difficulty Breathing?..... Y N
17. Any Other Lung Problems?..... Y N
18. Do You Smoke?..... Y N
19. Blood Disorders (i.e. Anemia)?..... Y N
20. Bruise Easily?..... Y N
21. Abnormal Bleeding Tendency?..... Y N
22. Jaundice, Hepatitis, or Liver Disease?..... Y N
23. Infectious Mononucleosis?..... Y N
24. Gallbladder Trouble?..... Y N
25. Fainting Spells?..... Y N
26. Convulsions/Epilepsy?..... Y N
27. Stroke?..... Y N

HAVE YOU HAD OR DO YOU HAVE...

28. Thyroid Trouble?..... Y N
29. Diabetes?..... Y N
30. Low Blood Sugar? Y N
31. Kidney Trouble?..... Y N
32. Are You on Dialysis?..... Y N
33. Swollen Ankles?..... Y N
34. Arthritis or Joint Disease?..... Y N
35. Joint Replacement?..... Y N
36. Osteoporosis?..... Y N
37. Stomach Ulcers?..... Y N
38. Contagious Diseases?..... Y N
39. Sexually Transmitted Diseases?..... Y N
40. AIDS or HIV Infection?..... Y N
41. Problems of the Immune System?..... Y N
42. A Tumor or Growth?..... Y N
43. Mental Health Problems?..... Y N
44. Are You on a Diet?..... Y N
45. Drugs?..... Y N
46. Alcoholic Beverages?..... Y N
47. Eye Diseases/Glaucoma?..... Y N
48. Radiation Treatment/Chemotherapy?..... Y N
49. Blood Transfusion?..... Y N
50. Pain and/or Clicking of Jaws?..... Y N
51. Malignant Hyperthermia?..... Y N
52. Cancer?..... Y N
53. Any other conditions? _____

To the best of my knowledge, the above medical information is accurate.

Signature of Patient/Parent or Legal Guardian: _____ **Date:** _____

PATIENT CONSENT FORM

AUTHORIZATION TO RELEASE DENTAL BENEFITS

I authorize the release of all dental information necessary to process insurance claims and hereby assign and authorize direct payment of all dental benefits to the undersigned:

**Michael and Angela Pernoud, DDS, PC
Hawk Ridge Dental Care
Lake St. Louis, MO**

Please remember that dental insurance is considered a method of deferred payment and is not a substitution for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. It is your responsibility to pay the balance in full if the insurance information you provide us proves false or otherwise ineffective. It is your responsibility to follow all guidelines of your insurance company. Information regarding any change in your insurance coverage must be provided prior to receiving service.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

This Assignment will remain in effect until revoked by me in writing. A signed photocopy of the Assignment is to be considered as valid as an original.

Signature of Patient/Guardian _____ **Date** _____

Signature of Responsible Party _____ **Date** _____

LIFETIME SIGNATURE ON FILE

I request that payment of authorized dental benefits be made on my behalf to Michael and Angela Pernoud, DDS, PC or Hawk Ridge Dental Care for any services provided. I authorize the release of any dental information needed to determine the benefits payable for related services.

Signature of Beneficiary _____ **Date** _____

FINANCIAL POLICIES

INSURANCE

1. As a courtesy, we will submit insurance claims for the patient unless other arrangements are made.
2. For patients who have dental insurance: Dental insurance is a contract between you and your insurance provider, not this office. Professional services rendered at this office are charged to the patient and/or responsible party, not to his/her insurance company. We allow time to process insurance claims before collecting our full fee as a courtesy to our patients and is neither an obligation on our part, nor is it an assumption thereof for any future claims.
3. As a courtesy, we will estimate what insurance is expected to cover for treatment. If there is a credit after payment from the insurance company is received, the policy holder will be issued a refund. If there is a balance, the policy holder will be responsible for the remaining amount.
4. As a courtesy, we will check your insurance status at your initial visit when possible. However, it is the insurance holder's responsibility to know his/her insurance plan, limitations, coverage status, etc. and represent this as truthfully as possible to the best of his/her knowledge. We cannot and will not assume any responsibility for the actual level of coverage you receive from your insurance company. The policy holder is ultimately responsible for the entire fee.

PAYMENT OF SERVICES RENDERED

1. The patient's payment will be collected at the time of service.
2. If the patient does not have insurance, full payment is due for the service(s) rendered at the time of treatment unless otherwise arranged.
3. We will do our best to work with your insurance company to collect payment. However, in order not to be subject to late fees, you have the responsibility to contact your insurance company to assure that payments are made for the services rendered and the account has been paid in full.
4. This office is not a party for divorce decrees. Adult patients are responsible for their portion at the time of service. The responsibility for minors rests with the accompanying adult.

LATE FEES

1. There is a \$33.00 fee for any returned checks. In addition, any other costs incurred by our office will be added to your account. Once added, this fee cannot be removed.
2. A late fee of \$33.00 per month will be applied to any account if the balance is unpaid for 30 days after the service has been rendered. Once added, this fee cannot be removed.
3. For any balance that is overdue and legal and/or collection assistance is necessary for the collection of the account, the responsible party will be liable for the fees incurred. All collection accounts are also subject to interest charges as allowed by law.

MISSED/CANCELED APPOINTMENTS

Periodontal Therapy Appointments/Doctor Appointments:

In order to reserve your appointment, ten percent (10%) of your treatment fee will be pre-collected at the time of scheduling. This payment is non-refundable if an appointment is cancelled or rescheduled with less than 48 hour notice. Upon completion of the scheduled appointment, the prepaid portion will be deducted from your estimated patient portion. If there is not a patient portion due at the time of service, the pre-collected amount will be refunded.

Recare Appointments:

After the second missed or cancelled appointment, \$30.00 will be pre-collected at the time of scheduling. This payment is non-refundable if an appointment is cancelled or rescheduled with less than 48 hour notice. Upon completion of the scheduled appointment, the prepaid portion will be deducted from your estimated patient portion. If there is not a patient portion due at the time of service, the pre-collected amount will be refunded.

I have read and understand Hawk Ridge Dental Care's Financial Policies.

Patient/Parent or Legal Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF HAWK RIDGE DENTAL CARE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notices of privacy practices that we have in effect. We realize these laws are complicated, but we must provide you with the following important information: How we may use and disclose your IIHI, Your privacy rights in your IIHI, Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367. (636)561-4540.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

1. Treatment. Our practice may use your IIHI to treat you. For example, we may use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people in our practice may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents. Finally we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your dental insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. Examples include: using and disclosing your information to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN SPECIAL CIRCUMSTANCES

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of: maintaining vital records, such as births and deaths; reporting child abuse or neglect; preventing or controlling disease, injury, or disability; notifying a person regarding potential exposure to a communicable disease; notifying a person regarding a potential risk for spreading or contracting a disease or condition; reporting reactions to drugs or problems with products or devices; notifying individuals if a product or device they may be using has been recalled; notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence) if the patient agrees or we are required by law disclose this information; notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example: investigations; inspections; audits; surveys; licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protective of the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official regarding: a crime victim in certain situations, if we are unable to obtain the person's agreement; a death we believe has resulted from criminal conduct; criminal conduct at our office; in response to a warrant, summons, court order, subpoena, or similar legal process; identifying/locating a suspect, material witness, fugitive, or missing person; an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator).

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorizations satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (a) an adequate plan to protect the identifiers from improper use and disclosure; (b) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (c) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research would not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosure to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Worker's Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367**. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by the practice will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that create the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment, or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the assistant; or the front desk using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367** or call **636-561-4540**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Privacy Officer, 8631 Highway N, Lake St. Louis, MO 63367** or call **636-561-4540**.