WELCOME TO THE PROVINCES DENTAL CARE

Name_____ Nickname_____
Address_____Unit#_____ Birth Date_____ Age_____ Sex_____
City _____State_____Zip_____ Single___ Married___ Widowed___ Other____
Home Phone_____ Social Security #_____
Work Phone_____ Employer_____
Cell Phone_____ Occupation_____
E-Mail_____ Who referred you to our office? (We would like to thank them!) _____

Person to notify in case of an emergency_____ Their Phone_____

Name of your Primary Dental Insurance

_____
Policy Holder's Name_____
Relationship to Patient_____
Insured's Birth Date_____
Social Security #_____
Insurance ID# (If different from SS#)_____
Claim Address_____
_____
_____
Insurance Phone #_____
Group #_____

Name of your Secondary Dental Insurance

_____
Policy Holder's Name _____
Relationship to Patient_____
Insured's Birth Date_____
Insured's SS#_____
Insurance ID# (If different from SS#)_____
Claim Address_____
_____
_____
Insurance Phone #_____
Group #_____

DENTAL HISTORY

REASON FOR TODAY'S VISIT_____
_____
FORMER DENTIST_____
CITY/STATE_____
DATE OF LAST DENTAL CARE_____
DATE OF LAST DENTAL XRAYS_____
PLEASE INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:
___BAD BREATH
___BLEEDING GUMS
___BLISTERS ON LIPS OR MOUTH
___BURNING SENSATION ON TONGUE
___CHEW ON ONE SIDE OF THE MOUTH
___CIGARETTE, PIPE, OR CIGAR SMOKING
___CLICKING OR POPPING IN JAW
___DRY MOUTH
___FINGERNAIL BITING
___FOOD COLLECTION BETWEEN TEETH
___FOREIGN OBJECTS
___GRINDING TEETH
___GUMS SWOLLEN OR TENDER
___JAW PAIN OR TIREDNESS
___LIP OR CHEEK BITING
___LOOSE TEETH OR BROKEN FILLINGS
___MOUTH BREATHING
___MOUTH PAIN WITH BRUSHING
___ORTHODONTIC TREATMENT
___PAIN AROUND EAR
___PERIODONTAL TREATMENT
___SENSITIVITY TO COLD
___SENSITIVITY TO HEAT
___SENSITIVITY TO SWEETS
___SENSITIVITY WHEN BITING
___SORES OR GROWTHS IN MOUTH
___TOBACCO, SMOKELESS / OTHER
HOW OFTEN DO YOU BRUSH?
_____
HOW OFTEN DO YOU FLOSS?
_____

Are you dissatisfied with your teeth, &/or their appearance?

_____

_____

THE PROVINCES DENTAL CARE

Patient_____ **Birthdate**_____ **Sex**_____

HEALTH HISTORY

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine) and Redux (dexfenfluramine)? [ ] YES [ ] NO

Place a mark to indicate if you have, or have had in the past, any of the following:

___AIDS/HIV
___ANEMIA
___ARTHRITIS, RHEUMATISM
___ARTIFICIAL HEART VALVE
___ARTIFICIAL JOINTS
___ASTHMA
___BULIMIA
___BLEEDING ABNORMALLY, W/ SURGERY, EXTRACTIONS
___BLOOD DISEASE
___CANCER
___CHEMICAL DEPENDENCY
___CHEMOTHERAPY
___CIRCULATORY PROBLEMS
___CONGENITAL HEART LESIONS
___CORTISONE TREATMENTS
___COUGH, PERSISTENT
___DIABETES
___EMPHYSEMA
___EPILEPSY
___FAINTING OR DIZZINESS
___GLAUCOMA
___HEADACHES
___HEART MURMUR
___HEART PROBLEMS
___HEPATITIS TYPE ___
___HERPES
___HIGH BLOOD PRESSURE
___JAUNDICE
___JAW PAIN
___KIDNEY DISEASE
___LIVER DISEASE
___LOW BLOOD PRESSURE
___MITRAL VALVE PROLAPSE
___NERVOUS PROBLEMS
___PACEMAKER
___PSYCHIATRIC CARE
___RADIATION TREATMENT
___RESPIRATORY DISEASE
___RHEUMATIC FEVER
___SCARLET FEVER
___SHORTNESS OF BREATH
___SINUS TROUBLE
___SKIN RASH
___SPECIAL DIETARY NEEDS
___STROKE
___SWOLLEN FEET OR ANKLES
___SWOLLEN NECK GLANDS
___THYROID PROBLEMS
___TONSILLITIS
___TUBERCULOSIS
___TUMOR OR GROWTH ON HEAD OR NECK
___ULCER
___VENEREAL DISEASE

Medical Marijuana Usage? [ ] YES [ ] NO
Do you wear contact lenses? [ ] YES [ ] NO
Women:
Are you pregnant? [ ] YES [ ] NO Due Date? _____
Are you nursing? [ ] YES [ ] NO
Are you taking birth control? [ ] YES [ ] NO

Medications	Allergies		
List any medications you are currently taking,	For your health and safety, please mark any		
and why you take it:	Known drug or material allergies:		
	___Aspirin	___Iodine	___Penicillin
	___Barbituates	___Latex	___Sulfa
Pharmacy Name	___Codeine	___Local Anesthetics	
Pharmacy Phone Number	Other (list):		

Physician's Name_____ Date of Last Medical Visit_____
Previous hospitalizations, serious illnesses, or operations: _____
_____

I understand that **providing incorrect or incomplete information can be very dangerous to my health**. It is my responsibility to inform the dental office of any changes in my medical status. To the best of my knowledge, I have provided The Provinces Dental Care with **accurate and complete** health and dental information. I authorize the dental staff to perform the necessary dental services I may need.

_____ _____ _____
Patient or Guardian Signature Printed Name Date

THE PROVINCES DENTAL CARE FINANCIAL POLICY

PLEASE READ & INITIAL EACH PARAGRAPH

We appreciate your selection of this office to serve your dental needs. Our interest is to provide our patients with the finest possible, quality dental care. We must attend to the financial aspects of dental treatment as well. Following is an overview of our office financial policy.

____ **Payment.** Payment in full is required at the time of service. For your convenience, we accept cash, debit, and credit cards, including Visa, Master Card, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit.

____ **Insurance, if applicable.** Dental Insurance never pays for 100% of all dental services. As a courtesy, in most cases, we will bill one dental insurance for your care, providing you give us the needed information for claim submission.

- ____At the time of service, we will request from you an initial payment, the estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.
- ____Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within thirty days from the date of service, the entire balance in full is your immediate responsibility. The account will then be considered aged 30 days.
- ____Questions and concerns with your dental coverage and the payment of your claim(s) are the sole responsibility of the insured, and is your responsibility to resolve with the insured's employer and/or dental insurance company. Your coverage is a result of the contract between the insured's employer and the dental insurance company, and our office has no control over payment or non-payment of your claims.
- ____As your dental care provider, we advise treatment that is in the best interest of your medical and dental health. Insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs.
- ____It is the sole responsibility of you, the patient, to familiarize yourself with the rules, terms, exclusions, clauses, and benefit limitations of your dental insurance policy.

____ **Estimates.** Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed upon your approval.

____ **Aged Account.** All charges are your responsibility, due at time of service. Failure to keep this account current may result in The Provinces Dental Care being unable to provide additional dental services. Default occurs after 30 days, and payment is due in full. I understand that Provinces Dental does not accept "payments" on balances due for services already received. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, up to and including, but not limited to, late fees, finance charges, collection agency fees, attorney's fees and court costs.

____ **Copyright** Any comment posted online in any way relating to The Provinces Dental or any Provinces Doctor or Employee, will be the sole right and property of The Provinces Dental, P.C., and the copyright of the content of the comment, rating, or review is hereby assigned to The Provinces Dental, P.C. to utilize or eliminate at our discretion, and/or in order to protect any patient's or employee's anonymity and privacy.

____ **Appointments.** If unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. **Notice of less than 48 hours will result in a minimum charge of $50.00, the amount to vary depending on the magnitude of the failed appointment.**

____ **Assignment of Benefit.** I agree to be responsible for all charges for dental services and materials. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize Assignment of Benefit to The Provinces Dental Care.

I have read, understand, and agree to the above.

_____	_____	_____
Signature of Person Responsible for Account	**Printed Name of Person Responsible for Account**	**Date**

THE PROVINCES DENTAL CARE
Notice of Privacy Practices

Dear Patient,

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we take the new federal (**HIPAA – Health Insurance Portability and Accountability Act**) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office. **What has changed? Why a policy now? Very good questions!**

The most significant variable that has motivated the federal government to implement HIPAA is the rapid evolution of computer technology and its uses in the healthcare community. **The government seeks to standardize the protection of your PHI – how your Personal Health Information is transmitted.** This challenges us to take a good look at how your information is used in our office, not only in our computers, but with the phone, fax, copy machines, and charts. This has been an important exercise for us because it has disciplined us to put into writing a policy and procedure to ensure the protection of your health information.

We want you to know about these policies and procedures which we developed to make sure your PHI will not be shared with anyone who does not require it. Our office is subject to state and federal law regarding the confidentiality of your health information and in keeping with these laws, **we want you to understand our procedures, and your rights as our valuable patient**.

Our promise to you: We will use and communicate your PHI only for the purpose of providing your treatment, obtaining payment, and conducting dental care operations. Your PHI will never be used for any other purpose unless we have asked for and gotten your permission.

How your Health Information may be used…

…To Provide Treatment

We will use your PHI inside our office to provide you with the best dental care possible! This may include office and clerical procedures used to streamline coordination between the Doctor, his Assistants, Hygienists, and business office staff. In addition, your treatment may require us to share your PHI with other entities such as referring Doctors, Clinical Laboratories, or your pharmacy.

…To Obtain Payment

We may include your PHI with paperwork sent to collect payment for the services you receive in our office, such as with insurance forms sent either through the mail or electronically. We will be sure to only work with companies with a similar commitment to the protection of your PHI.

…To Conduct Dental Care Operations

Your PHI may be used during performance reviews or training of our staff. It is possible your PHI would be disclosed during audits by insurance companies or government agencies as a part of their quality assurance or compliance reviews. Your PHI may be reviewed in the process of certification, licensing, or credentialing.

…In Patient Reminders

Because we believe regular care is very important to your dental health, we will remind you of an appointment you've scheduled or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your treatment or to inform you of treatment options that may be available for you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best possible preventative, restorative, and cosmetic treatment modern dentistry can provide. This may include postcards, folding postcards, letters, voicemail messages, and electronic reminders such as e-mail (unless you tell us that you do not want to receive these reminders).

…Abuse or Neglect

We will notify the proper government agency if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only

when we are compelled by our ethical judgment, when we are specifically required or authorized by law or with the patient's agreement.

...Public Health or National Security

We may be required to disclose PHI to federal officials or military authorities when it is necessary to complete an investigation related to public health or national security.

…For Law Enforcement

We may be required to disclose PHI to a law enforcement official for law enforcement purposes. An example would be if you are a victim of a crime or in order to report a crime.

…Family, Friends, and Caregivers

With your permission, we may share your PHI with those you tell us will be helping you with your home hygiene, treatment, medication, or payment. If there is an emergency, and you are unable to tell us what you want, we will use our very best judgment in sharing your PHI, and only when it will be important to those participating in providing your care.

…To Coroners, Funeral Directors, and Medical Examiners

We may be required by law to provide PHI to coroners, funeral directors, or medical examiners in order to determine a cause of death or prepare for a funeral.

…Research

Advances in dental knowledge often involve learning from the careful study of the dental histories of prior patients. Formal review of dental histories as a part of a research study will happen only under the ethical guidance of an Institutional Review Board.

Your Rights as a Patient

This new law is careful to describe that you have the following rights related to your PHI:

…Restrictions

You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

…Confidential Communications

You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

…Inspect and Copy

You have the right to inspect and copy your PHI.

…Amend

You have the right to amend your PHI.

…Disclosures

You have the right to receive an accounting of disclosures of PHI.

…Paper Copy

You have the right to obtain a paper copy of this notice from us upon request.

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

_____

Print Patient Name

_____

Signature of Patient or Responsible Party

_____ _____

Birth Date **Today's Date**

Office Staff Only:

Written acknowledgement could not be documented due to

[ ] Patient refused to sign

[ ] Personal representative not able to sign

[ ] Language, communication, or effects of disability impeded acknowledgement

[ ] Emergency care impeded acknowledgement

[ ] Other, please specify_____