Patient registration packet (confidential)

Thank you for selecting our dental health care team! Our office adheres to written policies and procedures to protect the privacy of the information you provide.

Patient information:

Last name:	First name:	Middle:	Suffix *(check)*: ☐ Sr ☐ Jr ☐ I ☐ II ☐ III	Date of birth *(mm/dd/yyyy)*:
Address:	City:	State:	Zip code:	Sex *(check)*: ☐ male ☐ female ☐ intersex
Mailing address *(if different)*:				Preferred gender identity:
Cell phone:	Home phone:	Work phone:		SSN:
Email address *(email is not secure)*:				
Emergency contact:	Relationship:			Phone number:

Parent or guardian, if patient is a minor:

Name of parent or guardian *(last, first)*:		Relationship:	
Mailing address *(if different)*:	City:	State:	Zip code:
Cell phone:	Home phone:	Work phone:	
Email address *(email is not secure)*:			

Dental insurance information:

Carrier:	Policy holder:	Subscriber ID:	Employer:	Date of birth *(mm/dd/yyyy)*:
Carrier *(secondary)*:	Policy holder:	Subscriber ID:	Employer:	Date of birth *(mm/dd/yyyy)*:

Medical insurance information:

Carrier:	Policy holder:	Subscriber ID:	Employer:	Date of birth *(mm/dd/yyyy)*:

Accommodations:

Do you have special needs requiring accommodation? *(check)* ☐ **yes** ☐ **no**	If yes, please explain:
Do you require a language interpreter? *(check)* ☐ **yes** ☐ **no**	If yes, what language:

Dental records:

Are you providing any additional information that you would like to include in your patient record? *(check)* ☐ **yes** ☐ **no**

If yes, what documentation? *(check)* ☐ **radiographs** ☐ **dental chart notes** ☐ **medical information** ☐ **referral letter** ☐ **other**

Other, please explain:

Note: If you would like our office to obtain records for you, please ask the front office staff for a records release form.

To allow us to provide the best possible care it is important that you fill this information out completely.

Dental health information:

Previous dentist name:	Phone number:	City/State:
Date of last exam:	Date of last dental cleaning:	
Purpose of dental visit?		
How often do you brush?	How often do you floss?	
Do you wear partial dentures or full dentures? *(check)* ☐ **yes** ☐ **no**	Do you have dry mouth? *(check)* ☐ **yes** ☐ **no** ☐ **sometimes**	
Do you clench or grind your teeth? *(check)* ☐ **yes** ☐ **no** ☐ **sometimes**	Have you had orthodontic work? *(check)* ☐ **yes** ☐ **no**	
Have you ever had a reaction to local anesthetic? *(check)* ☐ **yes** ☐ **no** If yes, please explain:		
Do you have any dental questions or concerns you would like to talk with the dentist about? *(check)* ☐ **yes** ☐ **no** If yes, please explain:		

Medical information:

Primary care physician:	City/State:	Phone number:
Are you currently under a doctor's care? *(check)* ☐ **yes** ☐ **no** If yes, please explain:		
Has your MD or DMD recommended premedication with antibiotics prior to procedures? *(check)* ☐ **yes** ☐ **no** If yes, please explain:		
Do you have any known allergies? *(check)* ☐ **yes** ☐ **no** If yes, please explain allergy reaction:		
Have you ever taken any oral Bisphosphonate medications? *(check)* ☐ **yes** ☐ **no** If yes, please explain what the medication was taken for: **Dosage/Frequency:** Please indicate *(check)*: ☐ **Actonel** ☐ **Fosamax** ☐ **Zometa** ☐ **Didronel** ☐ **Boniva** ☐ **Skelid** ☐ **other** *(please explain)*:		
Have you ever taken any intravenous bisphosphonate medications? *(check)* ☐ **yes** ☐ **no** If yes, please explain what the medication was taken for: **Dosage/frequency:** Please indicate *(check)*: ☐ **Bonefos** ☐ **Aredia** ☐ **Reclast** ☐ **Zometa** ☐ **other** *(please explain)*:		
Note: height and weight is asked for potential medication dosing, please do not estimate. **Patient's height:**	**Patient's weight:**	
(Women only) Are you pregnant or trying to conceive? *(check)* ☐ **yes** ☐ **no** If yes, **due date**:		Are you nursing? *(check)* ☐ **yes** ☐ **no**

Substance use and history:

Do you use tobacco? *(check)*: ☐ **current** ☐ **past** ☐ **never**	If current, how often and type?	How many years of use? If past, quit date?
Do you currently or have you ever used recreational drugs? *(check)*: ☐ **current** ☐ **past** ☐ **never**	If current, how often and type?	How many years of use? If past, quit date?
Do you consume alcohol? *(check)*: ☐ **current** ☐ **past** ☐ **never**	If current, how often?	

Current prescription and over the counter medications:

Note: If you need additional space list on back of form and check box ☐ If you are providing a separate list or document please check box ☐

Medication	Dosage and frequency	Reason for taking medication

Do you have or have you experienced any of the following medical conditions? Please check all that apply:

Heart/Blood Pressure Problems

☐ Heart Disease
If yes, type: _____
☐ Chest Pain
☐ Heart Attack
☐ Ineffective Endocarditis
☐ Rheumatic Fever
☐ Artificial Heart Valve
☐ Heart Murmur
☐ Arrhythmia
☐ Pacemaker
☐ Implantable Defibrillator
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Other: _____

Respiratory/Lung Problems

☐ Asthma
☐ COPD/Emphysema
☐ Sleep Apnea
☐ Other: _____

Endocrine Disorders

☐ Diabetes
if yes, type: _____
Last HbA1c Reading
Date Taken: _____
☐ Insulin Pump
☐ Thyroid Disease
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Parathyroid Disease
☐ Other: _____

Kidney/Liver Disease

☐ Kidney Disease
☐ Dialysis
☐ Hepatitis
if yes, type: _____
☐ Liver Disease
☐ Cirrhosis
☐ Other: _____

Blood Disorders

☐ Anemia
☐ Bleeding Disorder
if yes, type: _____
☐ Blood Thinners
☐ High Cholesterol
☐ Other: _____

Stomach/Intestine Disorders

☐ Special Diet
if yes, type: _____
☐ Ulcers
if yes, location: _____
☐ Acid Reflux
☐ Crohn's Disease
☐ Other: _____

Infectious Diseases

☐ HIV/AIDS
☐ MRSA *(check)* ☐ Active ☐ Inactive
if yes, location: _____
☐ Cold Sores
☐ Human Papillomavirus (HPV)
☐ Tuberculosis
If yes, date treatment ended:
_____

Neurologic/Psychiatric Problems

☐ Stroke
if yes, date: _____
☐ TIA (transient ischemic attack)
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Alzheimer's Disease
☐ Dementia
☐ Anxiety
☐ Dental Anxiety
☐ Depression
☐ Post-Traumatic Stress Disorder
☐ Epilepsy or Seizures
☐ Autism Spectrum Disorder
☐ ADHD/ADD
☐ Bipolar
☐ Schizophrenia
☐ Psychosis
☐ Migraines
☐ Fainting or Dizzy Spells
☐ Other: _____

Cancer/Oncology

☐ Cancer
if yes, type: _____
☐ Chemotherapy
if yes, date: _____
☐ Radiation Therapy
if yes, date: _____

Muscle/Bone/ Connective Tissue Disorders

☐ Artificial Joints
Joint: _____
Date Placed: _____
☐ Arthritis
if yes, type: _____
☐ Osteoporosis
☐ Gout
☐ Temporomandibular Joint Disorder
☐ Fibromyalgia
☐ Other: _____

Head/Ear/Nose/Throat Problems

☐ Vision Problems
☐ Wear Contact Lenses
☐ Glaucoma
☐ Hearing Impairment
☐ Seasonal Allergies
☐ Sinus Problems
☐ Other: _____

Eating Disorders

☐ Bulimia
☐ Anorexia
☐ Other: _____

Other

☐ Transplanted Organ(s)
☐ Implantable Medical Electronic Device
if yes, type: _____

If you checked any of the boxes above, please use the space below to provide more information

Please list any other medical conditions you have experienced that are not included above:

By signing this form, I acknowledge that the information provided in this packet is true and accurate to the best of my knowledge.

Signature of Patient or Guardian

Date

Relationship to Patient

Consent to dental procedures:

To allow Arrow Dental to provide the best possible care we may require certain oral diagnostics.

I hereby authorize Arrow Dental, LLC, Associate Dentists, Hygienists and/or such dental assistants, to perform routine dental care, a comprehensive exam or limited oral evaluation plus any diagnostics including x-rays upon the above named and/or any other therapeutic procedure that his/her/their judgment may dictate to be advisable for the patient's well-being.

If in Associated Dentist's opinion, the above named requires services of a specialist, he/she agrees to accept the referral and will be responsible for any expenses that may be incurred.

I certify that I have read this consent, or that it has been read to me, and that I understand the above. The nature and purpose of such operation(s), procedure(s), treatment(s), and/or services and the reasons why the same is (are) considered necessary of advisable have been explained to me.

Signature of Patient or Guardian

Date

Appointment policy:

Arrow Dental strives to provide you with the best possible care. In order to meet the needs of our patients we request that if you must cancel your appointment you provide us with a 24-hour notice so we can use that opportunity to schedule someone else in your time slot. If a patient arrives late by 10 minutes or more, we reserve the right to reschedule the patient to another day.

We understand that emergencies happen and sometimes things cannot be avoided so we will work with you to accommodate your dental and scheduling needs; However, two missed appointments or failure to cancel a scheduled appointment with less than a 24-hour notice may result in being placed on a cancellation list, being seen for emergency treatment only or dismissed from our practice.

Thank you for your understanding. Arrow Dental is proud to partner in your dental health.

Signature of Patient or Guardian

Date

Privacy policy/HIPPA/financial policy:

Please find and review our HIPPA Notice of Privacy Policy and our Financial Policy on the last three pages of this packet. You may remove those pages for your records.

I acknowledge receipt of the Arrow Dental Privacy Policy and Financial policy by signing.

Signature of Patient or Guardian

Date

Office use only/health history reviewed by provider:

Provider's signature

Date

Patient Financial Policy

Thank you for choosing Arrow Dental to be your dental provider. We strive to provide affordable treatment and financing options so that we can manage your dental needs to keep you at your optimal health.

This policy is to clarify our obligations to you so that we can work as a team. We communicate this ahead of time to each patient so that we can develop a good plan to address your dental needs without the stress of worrying about finances.

Arrow Dental has partnered with Care Credit to provide our patients a financing option to help with out of pocket expenses. We will provide you with the application information. It is your responsibility to apply. We do not hold any responsibility in your relationship with Care Credit.

For patients with dental insurance, Arrow Dental will submit any completed treatment to your dental insurance company as a courtesy to you. While we will file your insurance claim, we cannot guarantee benefits will be paid as estimated. The insurance contract you have exists solely between you and your insurance carrier and is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums. We will strive to inform you of the limits of your benefits however ultimately you are responsible for knowing your insurance plan and providing payment for any costs resulting from treatment rendered. Any questions or comments regarding your benefits should be directed to your insurance carrier.

1. Payment at the time of service is expected, including the estimated patient portion that insurance does not cover. Our office accepts the following payment methods: Cash, Check, MasterCard, Visa and Care Credit.
2. A statement for services rendered will be mailed to you at the end of each month. Receipt of payment is expected by the 15th of the month. The payment should be mailed with the perforated portion of the statement to establish the proper crediting of the account.
3. Your account is considered delinquent if the requested payment due is not received by the fifteenth (15th) of the month.
4. Delinquent accounts may be sent to a collection agency.

Notice of Privacy Practices

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2013 and remains in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

How we may use and disclose health information about you.

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals involved in your care or payment for your care. We may use and disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster relief. We may use and disclose your health information to assist in disaster relief efforts.

Required by law. We may use and disclose your health information when we are required to do so by law.

National security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Public health activities. We may use and disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect:
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Secretary or HHS. We may use and disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Judicial and administrative proceedings. If you are involved in a lawsuit or dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information request.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, medical examiners, and funeral directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing you PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost- based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirement of applicable law.

Disclosure accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request the accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the addition requests.

Right to request a restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the way or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to notification of breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services.