DAY ONE DENTISTRY

Patient Information

Patient's Name ____ Preferred Name ____________

Birthdate _____________ Social Security # ____________________________ Sex __________

Address ________________________________ City _________________ ST____ ZIP _______

Home Phone _____________________ Work Phone ______________________ Ext _________

Cell Phone ________________________ E-Mail _____________________________________

Employer ________________________ City ______________ Occupation ________________

Name of Responsible Party _______________________ Social Security # _______________________

Address if different ______________________ City ________________ ST ______ ZIP __________

Home Phone ________________________ Work Phone ___________________ Ext _________

Employer ______________________________ City _____________ Occupation ____________

In case of emergency, whom shall we notify other than spouse?

Name ____________________ Relationship ______________ Phone ______________________

How did you hear about us? (Check all that apply): ☐ Postcard ☐ Website ☐ Social Media (which one?):___________

☐ Friend/Relative (name):________________ ☐ Search Engine (Google, etc.) ☐ Other: _______________

PRIMARY DENTAL INSURANCE INFORMATION

POLICY HOLDER NAME ______________________________

INS CO NAME _____________________________________

INS CO ADDRESS __________________________________

INS CO CITY, ST, ZIP________________________________

INSURANCE PHONE _________________________________

GROUP / POLICY # _________________________________

SUBSCRIBER ID # __________________________________

BIRTHDATE ______________________________________

PATIENT RELATIONSHIP______________________________

SECONDARY DENTAL INSURANCE INFORMATION

POLICY HOLDER NAME ___________________________

INS CO NAME __________________________________

INS CO ADDRESS _______________________________

INS CO CITY, ST, ZIP ___________________________

INSURANCE PHONE ______________________________

GROUP / POLICY # ______________________________

SUBSCRIBER ID # _______________________________

BIRTHDATE ___________________________________

PATIENT RELATIONSHIP___________________________

Patient Acknowledgments:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company directly pay the dentist or dental practice the insurance benefit otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of me and my dependents and I have read the payment arrangement policy. I have also read the HIPAA Notice of Privacy Practices and I understand I can have a personal copy of the policy upon my request. I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

I have read the above: Signature ________________________________ **Date** ________________

(Parent or Guardian if a minor)

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Medical History

Patient's Name ____ Age _________________Weight _________

Name of Physician and their specialty ____Preferred Pharmacy_______________

Most recent physical examination ____ Purpose ___________________________

What is your assessment of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	**YES**	**NO**
1. Hospitalization for illness or injury	☐	☐
2. An allergic reaction to:		
☐ Aspirin, ibuprofen, acetaminophen, codeine		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulfa		
☐ Local anesthetic		
☐ Fluoride		
☐ Metals (nickel, gold, silver, ______________)		
☐ Latex		
☐ Other ______________________________		
3. Heart problems or cardiac stent in the last 6 months	☐	☐
4. History of infective endocarditis	☐	☐
5. Artificial heart valve/repaired heart defect (PFO)	☐	☐
6. Pacemaker or internal defibrillator	☐	☐
7. Artificial prothesis (heart valve or joints)	☐	☐
8. Rheumatic or scarlet fever	☐	☐
9. High or low blood pressure	☐	☐
10. A stroke (taking blood thinners)	☐	☐
11. Anemia or other blood disorder	☐	☐
12. Prolonged bleeding due to a slight cut (INR > 3.5)	☐	☐
13. Emphysema, shortness of breath, sarcoidosis	☐	☐
14. Tuberculosis, measles, chicken pox	☐	☐
15. Asthma	☐	☐
16. Breathing or sleep apnea, snoring, sinus issues	☐	☐
17. Kidney disease	☐	☐
18. Liver disease	☐	☐
19. Jaundice	☐	☐
20. Thyroid, parathyroid, or calcium deficiency	☐	☐
21. Hormone deficiency	☐	☐
22. High cholesterol or taking statin medication	☐	☐
23. Diabetes Type I or II (HbA1c= ___________)	☐	☐
24. Stomach or duodenal ulcer	☐	☐
25. Digestive disorders	☐	☐

	YES	**NO**
26. Osteoporosis/osteopenia (taking bisphosphonates)	☐	☐
27. Arthritis, rheumatoid arthritis, lupus	☐	☐
28. Glaucoma	☐	☐
29. Contact lenses	☐	☐
30. Head or neck injuries	☐	☐
31. Epilepsy/convulsions (seizures)	☐	☐
32. Neurologic disorders (ADD/ADHD, prion disease)	☐	☐
33. Viral infections and cold sores	☐	☐
34. Any lumps or swelling in the mouth	☐	☐
35. Hives, skin rash, hay fever	☐	☐
36. STI/STD	☐	☐
37. Hepatitis (type _____)	☐	☐
38. HIV/AIDS	☐	☐
39. Tumor/abnormal growth	☐	☐
40. Radiation therapy	☐	☐
41. Chemotherapy/immunosuppressive	☐	☐
42. Emotional problems	☐	☐
43. Psychiatric treatment	☐	☐
44. Antidepressant medication	☐	☐
45. Alcohol/street drug abuse	☐	☐
ARE YOU:		
46. Presently being treated for any other illnesses	☐	☐
47. Aware of a change in your health in the last 24 hours e.g. fever, shills, new cough, or diarrhea)	☐	☐
48. Taking medication for weight management (fen-phen)	☐	☐
49. Taking dietary supplements	☐	☐
50. Often exhausted or fatigued	☐	☐
51. Experiencing frequent headaches	☐	☐
52. A smoker, smoked previously or use chew tobacco	☐	☐
53. Considered a touchy person	☐	☐
54. Often unhappy or depressed	☐	☐
55. FEMALE – taking birth control pills	☐	☐
56. FEMALE – pregnant	☐	☐
57. MALE – prostate disorders	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment (e.g. Botox, collagen injections)

____

List all medications, supplements, and/or vitamins within the past two-years

Drug	Purpose	Drug	Purpose
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ____ Date _______________________

Doctor's Signature ____ Date _______________________

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DENTAL HISTORY

Patient's Name: ____ **Date of Birth:** __________________

Why are you changing dentists? ______________________________________

How long since the last visit to a dentist? ____

Name of previous dentist: _______________________________________

How did you find us? ____________________________________

Who may we thank for referring you? __________________________________

Reason for today's visit (circle what applies):

Check-up **Cleaning** **Pain** **Other**

Have you ever had a bad experience at the dentist? ________________________________

Have you had any complications following treatment? ________________________________

Have you had unfavorable reaction to dental anesthetic? _______________________________

Does dental treatment make you nervous? _______________________________________

Are your teeth sensitive to cold, hot? ____

Do your gums bleed when you brush or floss? ____________________________________

Do you grind your teeth? _______________________________________

Are you aware of sores or irritated areas in the mouth? ________________________________

Have you ever been treated for Periodontal Disease? _________________________________

How often do you brush? _______________________________________

How often do you floss? _____________________________________

Do you like your smile? ____________________________________

If you could change your smile, what would you like to change? (circle what applies):

Color **Close spaces** **Fix worn/broken teeth** **Shape** **Position/alignment** **Other**

I am interested in (circle what applies):

Whitening **Cosmetics** **Replace missing teeth** **Straight teeth** **White fillings**

Home care **Breath** **Other**

Date of last visit to the dentist: ____________ Date of last cleaning:___________ Any cavities in the past 3 years? Y / N

To ensure your visit is a great experience, please be sure to share any questions or concerns you would like us to know.

Signature ____ **Date** _______________________

(Parent or Guardian if a minor)

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Payment Arrangements

Thank you for choosing Day One Dentistry as your family's comprehensive dental healthcare provider. We want to provide you with the best service available. To keep your dental cost as low as possible and help reduce our administrative costs, we do require payment at the time a dental service is provided to all family members. Our goal is to provide affordable dental services without unnecessary financial stress.

Payment Options

1. **Cash/Check**. This includes money orders. Please note that a $30.00 service fee will be charged to your account on all returned checks.
2. **Credit Cards**. For your convenience, we accept all major credit cards for payment.
3. **Insurance Co-Payment.** Our practice accepts dental insurance payments and is in-network with Delta Dental. The total cost of your treatment is usually not covered by your dental insurance. As a courtesy, our office will file your insurance claim for you. We strive to have the latest insurance information to estimate the amount your insurance pays for the procedure(s); however, your insurance may determine payment differently than anticipated. Your insurance contract is between you, your employer, and the insurance company. We are not part of your contract. Regardless of what we may calculate your insurance company to pay, it is only an estimate. **We cannot guarantee what your insurance will pay and there may be a remaining balance owed by you**. If there is a remaining balance left after you and your insurance have paid, we will send you a statement for the remaining balance. Co-insurance and deductible are due the day of service.
   We also accept payment from out-of-network insurance companies. However, if your insurance provider chooses to reimburse you directly, you are responsible for payment in full at the time your dental treatment is provided. In addition, if your insurance provider fails to pay within 45-days after we submit your claim, you are responsible for the full cost (except those with Delta Dental).
   We encourage you to keep in mind that we file your insurance as a courtesy to you and ultimately it is your financial responsibility.
4. **Dental Savings Plan** membership for our patients who do not have dental insurance! Ask us for a brochure!
5. **Financing.** For our patients who will need to make payment arrangements for their healthcare needs, we offer financing! Ask us for a brochure!

The adult accompanying a minor is responsible for full payment. In the case of a divorce, the parent (or guardian of the minor) that brings the child in for dental treatment will be the responsible party regardless of legal arrangements. For unaccompanied minors, non-emergency treatment will be denied unless arrangements to pay the day of service by cash, check, or credit card have been made prior to the visit.
Should you need our services after-hours for emergency treatment, there will be a $182 fee in addition to any procedural costs incurred. This fee is not covered by insurance, and payment is due at the time of the after-hours visit.
If your account requires servicing by a collection agency or by an attorney, you are liable for the collection fees, attorney fees, and applicable court costs, in addition to your outstanding balance.
By signing this form, you agree to the above conditions and fees along with authorizing the release of any dental information necessary to process your insurance claim and all future claims.

I acknowledge that I have also read the HIPAA Notice of Privacy Practices (attached) and have been offered a copy of them if desired.

I have read the above: Signature ____ Date _______________________
(Parent or Guardian if a minor)

DAY ONE DENTISTRY

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 September 23, 2013, and will remain 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 listed 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 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 or disclose your health information to assist in disaster relief efforts.

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

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

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

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.

Secretary of HHS. We will 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.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a 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 requested.

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

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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 your 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 requirements 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 this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional 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 ways 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 a 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 (e-mail).

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 with 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.

Our Privacy Official: Wyley Wondercheck, DDS.