Vaughan Family Dentistry

Patient Information

Patient Name_____ Preferred Name _____

Gender: Male Female Relationship Status Married Single Divorced Widowed Separated

Date Of Birth_____ Social Security Number_____

Address_____
Street City State Zip

Email Address_____ Phone Number_____

Whom may we thank for referring you? _____

Spouse or Responsible Party Information

Name_____

Gender: Male Female

Date Of Birth_____ Social Security Number_____

Address_____

Email Address_____ Phone Number_____

Employer_____

Insurance Information

Name of Insured_____

Insured's Date of Birth_____ ID#_____ Group #_____

Employer_____

Relationship to Patient Self Spouse Child Other_____

Insurance Plan Name_____

Insurance Address_____

Secondary
Name of Insured_____

Insured's Date of Birth_____ ID#_____ Group #_____

Employer_____

Relationship to Patient Self Spouse Child Other_____

Insurance Plan Name_____

Insurance Address_____

Vaughan Family Dentistry
Medical History

Patient Name_____ Date of Birth_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions

Are you under a physicians care now? ☐ yes ☐ no

Explain: _____

Have you ever been hospitalized? ☐ yes ☐ no

Explain: _____

Have you ever had a serious head or neck injury? ☐ yes ☐ no

Explain: _____

Are you taking any medications, pills or drugs? ☐ yes ☐ no

Please List*: _____

Do you take, or have you taken, Phen- Fen or Redux? ☐ yes ☐ no

Explain: _____

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ☐ yes ☐ no

Explain: _____

Do you use tobacco? ☐ yes ☐ no

Explain: _____

Are you on a special diet? ☐ yes ☐ no

Explain: _____

Have you ever been told you have periodontal disease? ☐ yes ☐ no

Explain: _____

Do you use controlled substances? ☐ yes ☐ no

Explain: _____

Are you taking a blood thinner? ☐ yes ☐ no

Explain: _____

Women:

Are you pregnant or trying to get pregnant? ☐ yes ☐ no

Are you nursing? ☐ yes ☐ no

Are you taking oral contraceptives? ☐ yes ☐ no

*if the medications you are taking will not fit in the space provided, please provide a list to the front office staff to make a copy or list your medications on the back of this page.

CONTINUED ON BACK

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa Drug ☐ Other

If yes, please explain: _____

Please list any allergies not listed: _____

_____

_____

Do you have, or have you had, any of the following?

___AIDS/HIV POSITIVE
___Alzheimer's Disease
___Anemia
___Angina
___Arthritis/Gout
___Artificial Heart Valve
___Artificial Joint
___Asthma
___Atrial Fibrillation
___Blood Disease
___Blood Transfusion
___Breathing Problem
___Bruise Easily
___Cancer
___Chemotherapy
___Chest Pains
___Cold sores/ fever blisters
___Convulsions
___Congenital Heart Disorder
___Cortisone Medicine
___Diabetes
___Drug Addiction
___Easily Winded
___Emphysema
___Epilepsy or Seizures
___Excessive Bleeding
___Excessive Thirst
___Fainting Spells/ Dizziness
___Frequent Cough
___Frequent Diarrhea
___Frequent Headaches
___Glaucoma
___Irregular Heartbeat
___Hay Fever
___Heart Attack/ Failure
___Heart Murmur
___Heart Pacemaker
___Heart Stents
___Heart Trouble/ Disease
___Hemophilia
___Hepatitis A
___Hepatitis B or C
___High Blood Pressure
___High Cholesterol
___Hives or Rash
___Hypoglycemia
___Joint Replacement
___Kidney Problems
___Leukemia
___Liver Disease
___Low Blood Pressure
___Lung Disease
___Mitral Valve Prolapse
___Osteoporosis
___Pain in Jaw Joints
___Psychiatric Care
___Radiation Treatments
___Renal Dialysis
___Sinus Trouble
___Stomach Problems/ Ulcers
___Thyroid Disease
___Tumors or Growths

*If diabetic, what is your A1C?_____ When was your last reading?_____

*If taking Coumadin, what is your INR?_____ When was your last reading?_____

Have you ever had any serious illness not listed above? ☐ yes ☐ no If yes, Please explain:

_____

_____

PLEASE CONTINUE MEDICATION LIST HERE:

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature:_____ Date:_____

Doctor Signature:_____ Date:_____

VAUGHAN FAMILY DENTISTY

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical mental health or condition and related health care services.
Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your dentist, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, or conducting and arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist.
We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by la.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may as us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Print Name_____

Signature_____ Date_____

DENTAL OFFICE FINANCIAL AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

GENERAL:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes, but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and any other services not directly provided by the dentist.

MISSED APPOINTMENTS:
Unless we receive notice of cancellation 48 hours in advance, you will be charged $50.00 per appointment hour. Please help us to service you better by keeping scheduled appointments.

INSURANCE:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, we will file your insurance. **Be aware that due to the many differences in coverage/ benefits schedules, policies, exclusions, age limits, waiting periods, your insurance company may pay less than expected for services rendered. Some of the services provided may be non-covered.** We recommend a predetermination on all services over $250. A predetermination is a written proposal of work submitted to your insurance company on your behalf. It can take several weeks before the response of the insurance company gets back to us. Keep in mind we have no authority to speed up this process. If you choose to forego the predetermination and the insurance company denies your claim we will attempt to negotiate on your behalf up to a certain point. If an agreement with your insurance company cannot be reached regarding your denied claim, we will promptly inform you. **A predetermination does not guarantee payment from your insurance company.**

You are responsible for all charges incurred whether your insurance company pays or not. If your insurance company has not paid your claims within 45 days the balance will be billed to you, payable immediately.

PAYMENT:
FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS AND DEDUCTIBLES** are due at the time of service. For longer and more expensive appointments, we may request one half of patient estimated cost to reserve appointment time.

Please indicate the form of payment you wish to choose: ☐ Cash or Check
☐ Visa, MasterCard, Discover, American Express

If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature:_____

Date:_____

Vaughan Family Dentistry

I authorize Vaughan Family Dentistry permission to discuss any medical treatment and finances with the following individual(s).

Name (Please print)	Relationship
Name (Please print)	Relationship
Patient (Please print)	
Patient or Guardian Signature	Date