PATIENT REGISTRATION

Date: _____/_____/_____
How did you hear about us: _____-_____
Name of previous dentist: _____

PATIENT INFORMATION

Patient is: ○ Responsible Party ○ Policy Holder

First Name: _____ Last Name: _____Middle Initial ____ Preferred Name: _____
Birth Date: _____/_____/_____ ○ Male ○ Female Soc Sec: _____-_____-_____
Driver Lic#:_____ Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____EXT: _____Cell Phone: _____
Email: _____○ I would like to receive correspondences via e-mail
Emergency Contact Name: _____ Relationship: _____Phone #: _____
Preferred Pharmacy: _____ Pharmacy Phone: _____

ACCOUNT RESPONSIBLE PARTY (If someone other than the patient**)**

Responsible Party Name: _____ Relationship To Patient: _____
Birth Date: _____/_____/_-_____ ○ Male ○ Female Soc Sec: _____-_____-_____
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____EXT: _____ Cell Phone: _____
Alternate Phone Number: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____Insurance Phone # _____Employer:_____
Policy Holder Name:_____ Birth Date: _____/_____/_____
Soc Sec: _____- _____- _____ Member ID #:_____ Grp #: _____
Relationship to Policy Holder: ○ Self ○ Spouse ○ Child ○ Other

PLEASE DO FRONT AND BACK OF ALL PAGES

Are you under a physician's care now?	◯ Yes ◯ No	If yes	
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes	
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes	
Are you on a special diet?	◯ Yes ◯ No		
Do you use tobacco?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

HARBINS DENTAL

770-685-1415

Welcome to our practice! We appreciate the trust you have placed in us.

INSURANCE

Please understand that the contract is between you and the insurance co. and payment for services will ultimately be your responsibility. We will accept assignment of claims for primary insurance. **INITIAL: _____**

ALL DEDUCTIBLES AND FEE AMOUNTS NOT COVERED BY INSURANCE ARE DUE AT THE TIME OF TREATMENT.

Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. **If at the end of 60 days, your insurance company has not paid, you are responsible for the entire balance.** Upon request, we will supply you with a copy of the claim so that you can resubmit if necessary.

Please be advised that you may be billed for services that your insurance company will not cover due to exclusions or plan limitations. In most cases, a pre-treatment estimate can be sent to your insurance company, therefore giving us an estimated portion due by you at time of service. (Upon request) **INITIAL: _____**

Please be advised that we do not do amalgams (silver fillings) in our office. Most insurance apply alternate benefit on Composite (white) fillings at a reduced rate, making you responsible for balance owed.

OFFICE FEES

Payment is due at the time service is rendered. We accept cash, check Visa, Mastercard, Amex and Carecredit.

If you present a check for insufficient funds or stop payment on an issued check, you will be charged a $ 35.00 processing fee. In the event that your account is turned over to our collection agency, a 40% charge will be added on to the entire family balance. **INITIAL: _____**

CANCELLATION

If you break an appointment with our office, we ask for a 24 hour notice of cancellation.

If we do not receive a 24 hour notice, you will be charged a $50.00 fee for the scheduled appointment. This fee cannot be charged to your insurance company. If you repeatedly miss scheduled appointments you may be asked to pursue treatment elsewhere. **INITIAL: _____**

I have read and understand the statements outlined above.

SIGNED _____ DATE _____/_____/_____

PRINT _____DATE _____/_____/_____

Harbins Dental Associates

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCUSSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information.

We are also required to give you this notice about our privacy practices. Our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notices takes effect March 16, 2015 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made changes. Before we make a significant change in our privacy practices we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about your treatment, payment and healthcare operations.

For example

Treatment: We may use or disclose health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualification of healthcare professionals evaluating practitioner and provider performance conducting training programs accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization to use your health information, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization

while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of, (including identifying or locating), a family member, your personal representative or another person responsible for your care of your location, your general condition or death. If you are present, then prior to use or disclosure of tour information we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to your filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your authorization.

Required by Law: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you varied amounts for duplicate x-rays- $0.50 for each photocopied page. $25 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Harbins Dental Associates

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

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 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 complain 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.

Signed: _____ Date: _____

Harbins Dental Associates

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