PRATT
FAMILY DENTISTRY

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Today's Date _____

Patient Information:

Address:_____
City: _____ State: _____Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Gender: ❑ Male ❑ Female
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
To Receive correspondence via email, please provide email address: _____
Employement Status: ❑ Full-time ❑ Part-time ❑ Retired ❑ Unemployed ❑ Disabled
Student Status: ❑ Full-time ❑ Part-time ❑ Not Applicable Name of School: _____
Previous Dentist: _____ Date of Last Dental Visit: _____
Preferred Pharmacy Name and City: _____
Emergency Contact: _____ Emergency Contact #: _____

Responsible Party (if someone other than the patient):

First Name: _____ Last Name: _____ Middle Initial _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security Number: _____
Relationship to Patient: ❑ Spouse ❑ Parent ❑ Insurance Holder ❑ Other (Please Specify) _____

Primary Dental Insurance Information:

Name of Insured: _____
Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other (Please Specify) _____
Insured Social Security #: _____ Insured Birth Date: _____
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Company Address: _____
***Please provide us with your insurance card so we may make a copy for your records**

Secondary Dental Insurance Information:

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other (Please Specify) _____
Insured Social Security #: _____Insured Birth Date: _____
Employer: _____
Employer Address: _____
Insurance Company: _____
Insurance Company Address: _____
***Please provide us with your insurance card so we may make a copy for your records**

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DENTAL HISTORY

How did you hear about our office?

- ❑ Friend _____
- ❑ Google
- ❑ Facebook
- ❑ Magazine
- ❑ Yellow Pages
- ❑ Other _____

What is the reason for your visit today? _____

When was your last dental visit? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you use an electric toothbrush? _____

Do you use another device like a Waterpik or Air Flosser to clean between your teeth? ❑ yes ❑ no

Please mark any that apply to you:

- ❑ Sensitivity to cold/hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in or around mouth
- ❑ Loose teeth
- ❑ Dentures/partials
- ❑ Discolored teeth
- ❑ Dry mouth
- ❑ Bad breath
- ❑ Food trapping between teeth
- ❑ Broken teeth/fillings
- ❑ Bleeding gums
- ❑ Clenching/grinding teeth
- ❑ Mouth ulcers
- ❑ Crowded teeth
- ❑ Difficulty opening
- ❑ Pain in jaw joint
- ❑ Popping/clicking in jaw joint
- ❑ Pain in mouth

Do you have any other concerns about your teeth? _____

FINANCIAL POLICY

It is our pleasure to bill your insurance as a courtesy. However, the patient receiving service (or their legal guardian) is ultimately responsible for all fees incurred. We require you to pay for the estimated "patient portion" at the time of service. This may include a deductible, copay, and/or a percentage of each procedure. If your insurance has not made payment in full within 2 months of treatment, you will be responsible for paying your balance. We accept cash, checks, VISA, American Express, and Mastercard. We also offer financing through Care Credit. In case of default, patient and/or responsible party is liable for any and all collections and/or reasonable attorney fees. Check policy: If your check is returned for any reason, there will be a returned check fee of $35.

Please initial: _____

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MEDICAL HEALTH HISTORY

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

Yes No (Mark an "**X**" for yes or no)

- ❑ ❑ Cancer or tumor
- ❑ ❑ Chemotherapy
- ❑ ❑ Radiation therapy
- ❑ ❑ Heart ailment or angina
- ❑ ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ ❑ Rheumatic fever or rheumatic heart disease
- ❑ ❑ Artificial joint or valve
- ❑ ❑ High or low blood pressure
- ❑ ❑ Pacemaker
- ❑ ❑ Kidney disease
- ❑ ❑ Hepatitis or other liver disease
- ❑ ❑ Alcoholism
- ❑ ❑ Blood transfusion
- ❑ ❑ Diabetes
- ❑ ❑ Neurologic condition
- ❑ ❑ Epilepsy, seizures, or fainting spells
- ❑ ❑ Emotional condition
- ❑ ❑ Arthritis
- ❑ ❑ Herpes or cold sores
- ❑ ❑ AIDS or HIV positive
- ❑ ❑ Migraine headaches or frequent headaches
- ❑ ❑ Anemia or blood disorders
- ❑ ❑ Abnormal bleeding after extractions/trauma/surgery
- ❑ ❑ Hayfever or sinus trouble
- ❑ ❑ Allergies or hives
- ❑ ❑ Anaphylaxis
- ❑ ❑ Asthma
- ❑ ❑ COPD
- ❑ ❑ Emphysema
- ❑ ❑ Tuberculosis or other lung problems
- ❑ ❑ Gastric reflux or GERD

Do you smoke, vape or use chew tobacco? ❑ yes ❑ no

Do you drink alcohol? ❑ yes ❑ no

If yes, how many drinks per week? _____

Do you have sleep apnea, snore heavily, or breath abnormally while sleeping? ❑ yes ❑ no

Are you taking any controlled substances? ❑ yes ❑ no

Are you recovering from a drug addiction? ❑ yes ❑ no

Women:

- ❑ Pregnant or may be pregnant, Expected due date: _____
- ❑ Nursing

Are you allergic to, or have you reacted adversely to any of the following? (Please check any that apply)

- ❑ Latex
- ❑ Penicillin
- ❑ Minocycline/Tetracycline
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Peanuts
- ❑ Nickel
- ❑ Other:_____

Are you taking any of the following? (Check any that apply)

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Redux or Phen-Fen
- ❑ Osteoporosis medicine (Reclast, Boniva, Fosamax, Actonel, Zometa, Aredia or other Bisphosphonates)

Please list all medications you are taking (or provide a list):

Medication	Reason

Has a doctor told you to take a pre-medication antibiotic prior to dental appointments?

- ❑ Yes – for what condition? _____
- ❑ No

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

Please list any major surgeries you have had or will soon have:_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent/guardian) _____ Date_____

PRATT
FAMILY DENTISTRY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY PRATT FAMILY DENTISTRY AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share your information other than what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(OVER)

PRATT
FAMILY DENTISTRY

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve you care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – **usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.**

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Ashley Pratt, RDH, Privacy Officer, & Manager
ashley@prattdds.com 910-692-7761 Effective date: 7/2017

PRATT
FAMILY DENTISTRY

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

PRATT
FAMILY DENTISTRY

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Communications between Patients and their Families, Friends, or Caregivers

This form allows Pratt Family Dentistry (Name of Practice) to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and those you list on this form. Signing this form is optional, is not required to receive treatment, and does not expire until you end it in writing.

Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ (mm/dd/yyyy) **Main Contact Number:** (___) _____
☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

COMMUNICATING WITH YOU

PHONE

☐ Main Contact Number Above
☐ Other: ( ) _____
☐ Home ☐ Cell* ☐ Work

DETAILED MESSAGES PERMITTED

☐ text (SMS)* ☐ voicemail/answering machine ☐ None
☐ text (SMS)* ☐ voicemail/answering machine ☐ None

EMAIL*

☐ _____
☐ All information from this practice
☐ Appointment information only (request/confirm/cancel)
☐ Data breach notifications
☐ Billing/insurance information

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS

☐ This practice may communicate to the family members, friends, or caregivers listed below.

Spouse/Partner: _____ (First and Last Name)
Phone: ( ) _____
Email:* _____

Other: _____ (First and Last Name)
Phone: ( ) _____
Email:* _____
Relationship: _____

Check the box next to each type of information this practice may share.

☐ All information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance
☐ Other: _____

Do not include:

☐ Mental health records ☐ Communicable diseases (e.g., HIV/AIDS) ☐ Alcohol/drug abuse treatment

* I understand that emails and texts are not always secure ways to communicate and could be intercepted and read by a third party. I am willing to accept this risk. This practice is not responsible for the privacy or security of your health information once it is sent to you, or the recipient(s) listed above.

PRATT
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YOUR PHOTOS & MULTIMEDIA

	Photos/Images may be used/posted:
☐ Photo received from you or personal representative	☐ In office
☐ Photo taken by staff (e.g., pre/post procedure)	☐ On office's website
☐ Other:_____	☐ Other: _____

PATIENT RIGHTS & SIGNATURE

- You can end this authorization at any time in writing. See our Notice of Privacy Practices for exceptions. A termination will not apply to any releases of information that happen before we receive a written termination from you.
- The recipient of the information could use or release it in a way that federal or state laws do not protect. This practice is not responsible for the privacy or security of your health information after it is sent to those listed on this authorization.
- You can review or copy the information that will be used or released as described in this authorization.
- You do not have to sign this authorization to receive treatment from this practice.
- You understand that the information that will be used or released might include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse unless you exclude it above.
- All changes or updates to this form must be made in writing and signed by you (patient) or your personal representative. Minor edits (e.g., new phone number) can be made on this form, initialed, and dated instead of requiring a new form.

_____ _____

Patient/Personal Representative Signature **Date:** **mm/dd/yyyy**

Printed name and description of Personal Representative's authority (e.g., healthcare power of attorney)
(Attach documentation to support the personal representative's authority if not already on file with the practice)

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been terminated: _____

mm/dd/yyyy

The termination must be in writing and filed with the original authorization.

Date original signed authorization received: _____

mm/dd/yyyy

☐ Copy of original authorization provided to patient/personal representative (check if yes)

Notes: _____

_____

It is recommended that the practice review this form with the patient or their personal representative periodically for changes (e.g., annually with insurance verification).