Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI
Gender (M/F): ____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Address: _____
Street Apartment #

_____
City State Zip Code
Phone #'s: Home _____ Work _____ Ext. _____

Cell _____Other_____ Emergency Contact_____
Name Ph #
E-Mail Address for Appointment Confirmations:_____

Employer: _____
Name City State
Who Referred You (Please Circle One): Google Drive By Phone Book Patient Family Friend

Name of Referring Person to Thank: _____Other (please specify): _____

Responsible Party (If Patient is a Minor)

Name: _____
Last First MI
Gender: (M/F): ____ Marital Status: _____ Birth Date: _____ Social Security #: _____

Address: _____
Street Apartment #

_____
City State Zip Code
Phone #'s: Home _____ Work _____ Ext. _____

Cell _____ Other _____

E-Mail Address: _____

Dental Insurance Information

Primary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID/SSN#: _____ Group #:_____
Insured's Address (if different from above): _____
Insured's Employer Name and Address (If Different): _____

Patient's Relationship to Insured (please circle): Self Spouse Child Other
Insurance Plan Name and Address: _____

Secondary
Name of Insured: _____
Last First MI
Insured's Birth Date: _____ ID/SSN#: _____Group#: _____
Insured's Address (if different from above): _____
Insured's Employer Name and Address: _____

_____
Patient's Relationship to Insured (Please circle): Self Spouse Child Other
Insurance Plan Name and Address: _____

IF YOU ARE TAKING MEDICATION FOR ANY CONDITION, PLEASE LIST IT BELOW

PAST OR CURRENT MEDICAL CONDITIONS (check all that apply)

- ☐ Artificial Heart Valve
- ☐ Artificial Joint (Date: _____)
- ☐ Bacterial Endocarditis
- ☐ Blood Thinner
- ☐ Chemotherapy (Date: _____)
- ☐ Heart Attack (Date: _____)
- ☐ Heart Surgery (Date: _____)
- ☐ Heart Murmur
- ☐ Latex Allergy
- ☐ Radiation (Date: _____)
- ☐ Stroke (Date: _____)
- ☐ Treatment for Osteoporosis

- ☐ Aids or Exposed to Aids
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Ankles Swell During Day
- ☐ Arthritis
- ☐ Aspirin Allergy
- ☐ Asthma/COPD
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer/Tumor (Date: _____)
- ☐ Codeine Allergy
- ☐ Cold Sores
- ☐ Congenital Heart Lesions
- ☐ Cortisone Medication
- ☐ Cough Chronic
- ☐ Diabetes
- ☐ Drug Abuse (Date: _____)
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Hepatitis A (Infectious
- ☐ Hepatitis B (Serum)
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Metal Allergy
- ☐ Nervousness
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Penicillin Allergy
- ☐ Psychiatric Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Sulfa Allergy
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Wake-Up Short of Breath
- ☐ Yellow Jaundice
- ☐ Do you use Tobacco?
- ☐ Are you pregnant?
- ☐ Are you on Birth Control?

Please list anything you are allergic to that is not listed above: _____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any diseases or conditions not listed above: _____

_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH OR MEDICATIONS, I WILL INFORM THE DENTIST AT MY NEXT APPOINTMENT.

SIGNATURE: _____ **DATE:** _____

CONSENT TO PROCEED

I authorize the doctors or associates of Today's Dentistry (Dental Partners) or assistants as he/she May designate to perform those procedures as may be deemed necessary or advisable to maintain my Dental health or the dental health of any minor or other individual for which I have responsibility, Including arrangements and/or administration of any sedative (including nitrous oxide), analgesic, Therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, Therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side Effects, which may include but are not limited to bruising, hematoma, cardiac stimulation, muscle Soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles Break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the Eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings And basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly Quite painful both during and after completion of treatment. After lengthy appointments jaw Muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful During and/or after treatment. Although rare it is also possible for the tongue, cheek or other oral Tissue to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some Cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental Instruments, drill components, etc, may be aspirated (inhaled into the respiratory system) or Swallowed. This unusual situation may require a series of x-rays to be taken by a physician Or hospital and may in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, If any, which may be associated with general preventive and operative treatment procedures In hopes of obtaining the potential desired results, which may or may not be achieved, for my Benefit or the benefit of my minor child or ward, I acknowledge that the nature and purpose of the Foregoing procedures have been explained to me if necessary and I have been given the opportunity To ask questions.

Patient Name: _____

Signature: _____ **Date:** _____

(Patient, legal guardian or authorized agent of patient)

Witness: _____ **Date:** _____

Today's Dentistry Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience we accept cash, check, Master Card, Visa, Discover, American Express and Care Credit. A service charge of 1.5% monthly or 18% annually may be charged on accounts exceeding 90 days, unless previously written financial arrangements are satisfied. All accounts 90 days past due will be considered delinquent and will be reported to Action Collection Service.

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If cancellations within the 24 hour period occur, or, an appointment is failed without notice, a $25 fee may be charged.

Insurance Explanation

Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, we bill your insurance plan directly. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list); however, we are not preferred providers with all of the ones we accept. It is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

I hereby authorize payment from my insurance company to the dentist or group listed below. * I understand I am responsible for all charges whether or not paid by insurance. *

Refunds

If your estimated patient portion results in a credit to your account you may leave the credit on file for future dental visits or we will gladly refund any requested credits. Please allow up to 14 business days to process your request.

Signature: _____ Date:_____

Parent (If Minor): _____ Date:_____

NOTICE OF PRIVACY PRACTICES
Dental Partners, PLLC

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Dental Partners agree that we will not post anything on the internet or other publications about our patients. You agree that you will not post anything on the internet or other publications about our office, doctors or staff. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 12, 2008 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Today's Dentistry
Dental Partners, PLLC
Klint R Keller, DDS
Jason B Hammer, DMD
Kaci B Jensen, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may Refuse to Sign This Acknowledgement"

I, _____, have reviewed a copy of this Office's Notice of Privacy Practices.

Patient Name (Printed): _____

Signature: _____

Date: _____

_____Office Use Only_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (Please Specify)
