## PATIENT INFORMATION

Patient Name: _____DOB: _____ Sex: _____ Age: _____ SSN: _____ M S D W

Home Address: _____ City: _____ State: _____ Zip Code: _____

Employer/Occupation: _____ Work Phone #: _____

Spouse/Both Parents Name: _____ Telephone #s: _____

Emergency Contact: _____ Relationship: _____ Telephone #: _____

Whom May we thank for referring you to our office: _____

## RESPONSIBLE INFORMATION

Person responsible for account: _____ DOB: _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

## INSURANCE INFORMATION

Subscriber's Name: _____ DOB: _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Insurance Co: _____ In. Co. Address: _____

Insurance Co. Phone #: _____Group #: _____ Policy ID #: _____ Relationship to Patient: _____

## SECONDARY INSURANCE INFORMATION

Subscriber's Name: _____ DOB: _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Insurance Co: _____ In. Co. Address: _____

Insurance Co. Phone #: _____Group #: _____ Policy ID #: _____ Relationship to Patient: _____

## METHOD OF PAYMENT:

To reduce our administrative costs and keep our fees to you as low as possible, we ask that you pay your co-payment at the time you receive treatment. Please indicate below the method of payment you intend to use to pay for your dental treatment, including your co-payment.

**Payment Options:**

- ☐ Cash or Check ☐ Visa / MasterCard / Discover/American Express
- ☐ Financial Lending Institution (please inquire with financial coordinator if interested in this option)

**Policies:**

All fees are payable at the time of service. Insurance can be filed as a courtesy, but your co-payment is due at the time of service. If payment is not received within sixty (60) days of filing your insurance, we will bill you for the amount due. A 1.5-% monthly finance charge will be assessed on your account if it becomes thirty (30) days past due. To expedite your treatment plan and reduce time required to make possible payment arrangements, a credit report may be obtained.

**Authorization:**

I hereby authorize payment directly to Michael R. Dana, DDS, PC {Dana Dental Arts} for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dana Dental Arts to administer such diagnostic, photographic and therapeutic procedures as may be necessary for my complete dental care. My signature permits Dana Dental Arts to use photographs for educational purposes or commercial use. The information on this page and on the medical/dental histories page are correct to the best of my knowledge. I grant the right to the dentist to release my medical/dental treatment to third party payors and/or authorized health care professionals.

_____ _____

**SIGNATURE** **DATE**

July '14

# GENERAL HEALTH HISTORY

Please complete the information below as accurately as possible. We are interested in your overall health and think our interest in your appearance and comfort is one of the reasons you are here. In order to prevent disease and infection, or to eliminate any present disease or infection, it is necessary to know as much about your general health as possible. The information you provide will help us to reach an accurate analysis of your oral health so that we can better serve you. This information will be held confidential.

Name _____ Date _____

Age _____ Home Phone _____Cell Phone _____ Work Phone_____ Email _____

Birth Date _____ Sex _____ Height _____ Weight _____ Name of Medical Doctor _____Last Visit _____

Dr.'s Phone _____ Emergency Contact _____ Emergency Phone _____

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, drugs or dietary supplements? ○ Yes ○ No If yes, drug and purpose: _____
_____
Do you take, or have you taken Phen-Fen or Redux? ○ Yes ○ No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No If yes, please explain: _____
Are you on a special diet? ○ Yes ○ No If yes, please explain: _____
Do you have, or have you ever had an eating disorder? ○ Yes ○ No If yes, please explain: _____
Do you use tobacco? ○ Yes ○ No If yes, please explain: _____
Do you use controlled substances? ○ Yes ○ No If yes, please explain: _____
Do you have any information that you or your physician recommend you let your dentist know prior to treatment? ○ Yes ○ No If yes, please explain: _____

Women: Are you: Pregnant/trying to get pregnant? ○ Yes ○ No Taking Oral Contraceptives ○ Yes ○ No Nursing ○ Yes ○ No

Are you allergic to any of the following? ○ Acetaminophen ○ Acrylic ○ Aspirin ○ Codeine ○ Fluoride ○ Ibuprofen ○ Latex ○ Local Anesthetics ○ Metal ○ Penicillin ○ Sulfa drugs ○ Other, if yes, please explain:_____

**DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?**

| | | | |
|---|---|---|---|
| ○ AIDS/HIV positive | ○ Cortisone medicine | ○ Hepatitis A | ○ Prolonged bleeding-i.e. slight cut INR>3.5 |
| ○ Alcohol dependency | ○ Depression (taking medication) | ○ Hepatitis B or C | ○ Psychiatric care/emotional problems |
| ○ Alzheimer's Disease | ○ Diabetes HbA1c___ ○ insulin pump | ○ Herpes | ○ Radiation treatment |
| ○ Anaphylaxis | ○ Digestive disorder (i.e. gastric reflex) | ○ High blood pressure | ○ Recent weight loss |
| ○ Anemia or other blood disorder | ○ Drug addiction | ○ High cholesterol | ○ Renal dialysis |
| ○ Angina | ○ Easily winded | ○ History of infective endocarditis | ○ Rheumatic fever |
| ○ Arthritis/gout | ○ Emphysema or sarcoidosis | ○ Hormone deficiency | ○ Rheumatism |
| ○ Artificial heart valve, repaired heart defect (PFO) | ○ Epilepsy/Seizures | ○ Hypoglycemia | ○ Scarlet fever |
| ○ Artificial joint (i.e. knee, hip) | ○ Excessive bleeding | ○ Irregular heartbeat | ○ Shingles |
| ○ Asthma | ○ Excessive thirst | ○ Jaundice | ○ Sickle cell disease |
| ○ Blood disease | ○ Fainting spells/dizziness | ○ Kidney problems | ○ Sinus trouble |
| ○ Blood transfusion | ○ Frequent cough | ○ Leukemia | ○ Spina bifida |
| ○ Breathing problems | ○ Frequent diarrhea | ○ Liver disease | ○ Sleeping problems/sleep apnea |
| ○ Bruise easily | ○ Frequent headaches | ○ Low blood pressure | ○ Stomach/intestinal disease |
| ○ Calcium deficiency | ○ Genital herpes | ○ Lumps or swelling in the mouth | ○ Stroke |
| ○ Cancer-type _____ | ○ Glaucoma | ○ Lung disease | ○ Swelling of limbs |
| ○ Chemotherapy | ○ Hay fever/seasonal allergies | ○ Mitral valve prolapse | ○ Thyroid disease |
| ○ Chest pains | ○ Heart attack/failure | ○ Neurologic disorder (i.e. ADD) | ○ Tonsillitis |
| ○ Cold sores/fever blisters (or other viral sores) | ○ Heart murmur | ○ Osteopenia (taking bisphosphonates) | ○ Tuberculosis |
| ○ Congenital heart disorder | ○ Heart pace maker or implantable defibrillator | ○ Osteoporosis | ○ Tumors or growths |
| ○ Contact lenses | ○ Heart trouble/disease | ○ Pain in jaw joints | ○ Ulcers (i.e. stomach, duodenum) |
| ○ Convulsions | ○ Hemophilia | ○ Parathyroid disease | ○ Warfarin/Coumadin |

Have you had any serious illness not listed above? ○ Yes ○ No If yes, please explain _____

**DENTAL HISTORY** Purpose of dental visit_____
Previous dentist's name _____ Last visit _____ Are you generally nervous ○ Yes ○ No
What do you fear most during dental treatment? _____ What do you think of your teeth? _____
Do you have: sinusitis ○ Yes ○ No any tooth discomfort ○ Yes ○ No tooth sensitivity to hot, cold or sweets ○ Yes ○ No gums bleed easily when brushing ○ Yes ○ No
Do you desire: whiter teeth? ○ Yes ○ No cosmetics? ○ Yes ○ No dental implants? ○ Yes ○ No artificial teeth ○ Yes ○ No save teeth if practical ○ Yes ○ No

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.

Print name of patient, parent or guardian _____ SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE_____
**PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.**

# MICHAEL R. DANA, DDS, PC { Dana Dental Arts }

1306 N Main Street, Spearfish, SD 57783 605.642.7727

1814 Fifth Street, Rapid City, SD 57701 605.342.6038

# Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee of $20.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

## 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 the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*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 Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and 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 services.*

### How else can we use or share your health information?

We are allowed or required to share your 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. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

**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 medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**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 that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can 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 an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- 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 health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

## Changes to the Terms of 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 web site.

**Effective Date of this Notice:** September 23, 2013

- Privacy contact person:  Kim
- Phone number: 605.642.7727
- Email: officeadministrator@danadentalarts.com

# DANA DENTAL ARTS

**1306 Main Street, Spearfish, SD 57783 ***605.642.7727*** 1814 Fifth Street, Rapid City, SD 57701 ***605.342.6038*****

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices

Please Print Name Signature Date

Child(ren) name(s) {if under 18 years of age}

Cell phone # Email address

### DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Patient SSN_____

Patient DOB _____

If you would like us, at Dana Dental Arts, to answer all dental/medical questions freely, especially where our response requires disclosure of your protected health information, please complete this form.

May we, at Dana Dental Arts, speak with someone else regarding your dental/medical care? Yes ○ No ○

| Name of person | Relationship | Specific information | Phone # | Address |
|---|---|---|---|---|
| | | | | |
| | | | | |

Purpose: I am requesting this designation so that the named person(s) can handle all questions and issues related to my eligibility for coverage, plan benefits, payment of claims and preauthorization of treatment as well as the financial aspect of my dental treatment. This authorization form allows Dana Dental Arts to disclose and discuss past, present and future information with the person(s) designated above until I revoke this designation in writing.

**For Office Use Only**

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

○ Individual refused to sign ○ Communications barriers prohibited obtaining the acknowledgment

○ An emergency situation prevented us from obtaining acknowledgment ○ Other (Please Specify) _____

**Michael R. Dana, DDS, PC {DANA DENTAL ARTS} PHOTO/TESTIMONIAL RELEASE FORM**

**PERMISSION TO USE IMAGE/TESTIMONIAL DATA**

**I, _____, give Michael R. Dana, DDS, PC {DANA DENTAL ARTS}, it's employees, designees, agents, independent contractors, legal representatives, successors and assigns, and all persons or departments for whom or through whom it is acting, the absolute right and unrestricted permission to take, use my name, testimonial and biographical data and/or publish, reproduce, edit, exhibit, project, display and/or copyright photographic images or pictures of me or my child(ren), whether still, single, multiple, or moving, or in which I (they) may be included in whole or in part, in color or otherwise, through any form of media (print, digital, electronic, broadcast or otherwise) at any campus or elsewhere, for art, advertising, recruitment, marketing, fund raising, publicity, archival or any other lawful purpose.**

**I waive any right that I may have to inspect and approve the finished product that may be used or to which it may be applied now and/or in the future, whether that use is known to me or my child(ren) or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image or product.**

**I release and agree to hold harmless, DANA DENTAL ARTS, its Board of Regents, officers, employees, faculty, agents, nominees, departments, and/or others to whom or by whom DANA DENTAL ARTS is acting, of and from any liability by virtue of taking of the pictures or using the testimonial/biographical data, in any processing tending towards the completion of the finished product, and/or any use whatsoever of such pictures or products, whether intentional or otherwise.**

**I certify that I am at least 18 years of age (of if under 18 years of age, that I am joined herein by my parent or legal guardian) and that this release is signed voluntarily, under no duress, and without expectation of compensation in any form now or in the future.**

**_____ Name (Please Print)**

**_____ Signature**

**_____ Date (Please Print)**

**_____ Signature of parent/legal guardian if under 18 years of age**