TIME 07:40 AM DATE 6/20/2017

# PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

## Responsible Party ( if someone other than the patient )

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

## Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

### Section 3

Referred by

Emergency Contact

Emergency Contact #

Physician`s Name

Physician`s number

Employer

## Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

## Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 7:41 AM | W. Eric Gladden, D.M.D. | Date 6/20/2017

# Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 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

Comments:

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:_____

Gladden Dental

**Dental Treatment Consent Form**

I understand that I will be informed of my dental conditions and any necessary treatment options. I request and authorize Dr. Gladden and his staff to perform the work described to me by Dr. Gladden or his staff.

I understand that no guarantee can be promised, and I give my free voluntary consent for treatment. I realize that Dr. Gladden may discover conditions requiring different treatment from that which was planned, and I give my permission for those additional procedures that are advisable in the exercise of professional judgment.

I understand that to numb the area that will be treated, local anesthesia may be used. I understand that there are risks involved. These risks include but are not limited to bleeding at injection site, swelling, pain or a numb feeling of the chin, lip, cheek, gums, teeth, or tongue lasting for weeks, months, or may even be permanent.

I understand that dentistry is not an exact science and therefore reputable practitioners can not fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read and understand this form and ask any question related to my dental treatment.

Patient's Name Date

Patient's (or Legal Guardian's) Signature Date

Gladden Dental

## Dental Practice Financial Policy

The following is a statement of our Financial Policy for services provided within our office and do not apply to any testing, diagnostic procedures performed outside of this practice, or referrals to any specialist. We require you to read and sign this document prior to treatment in our office.

## Patient Responsibility

INSURANCE- All professional services rendered are charged to the patient and are due at time of service. As a courtesy, this practice will file your claim with your insurance carrier; however the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. If the claim is not paid within 45 days, the balance becomes the responsibility of the patient.

Initial_____

INSURANCE-Insurance carriers typically do not cover all dental costs. Some pay fixed allowances for each procedure and office visit while others pay a percentage of the cost. It is the patient's responsibility to understand their insurance coverage.

Initial_____

Due to insurance regulations, co-pays are due at time of service. If there is no insurance, balance is due at time of service.

Initial_____

When you receive a statement, you are requested to pay the balance in full upon receipt of the statement. If for some reason you do not agree with the balance due amount, you are requested to contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance over to an outside collection agency for recovery.

Initial_____

I understand that I am required to give 48 hours notice to cancel my appointment and that broken or missed appointments may result in a $37.00 fee per appointment.

Initial_____

I understand that I am financially responsible to the Practice of W. Eric Gladden, D.M.D., P.C.
If my account becomes past due and has to be turned over to a third party collection agency, there will be a collection fee of 35% added to my balance.

Initial_____

| **Patient Name (please print)** | **Signature of Patient/Responsible Party** | **Date** |
|---|---|---|

## Assignment of Insurance Benefits

I hereby assign and authorize my insurance benefits to be paid directly to
W. Eric Gladden, D.M.D., P.C.

| **Patient Name (please print)** | **Signature of Patient/Responsible Party** | **Date** |
|---|---|---|

Gladden Dental

* You May Refuse to Sign This Acknowledgment*

**I have received a copy of this office's Notice of Privacy Practices.**

Print Name:_____

Signature:_____

Date:_____

**For 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/15, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the

dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Fundraising.** We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**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 if you 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 complaint 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.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Lisa Collins
Telephone: 912-354-4133 Fax:912-354-4833
Address: 807 East 65th Street
E-mail: lisa@gladdendental.com