

## PATIENT REGISTRATION

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Patient Is: ☐ Policy Holder☐ Responsible Party

Responsible Party (if someone other than the patient) \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ ☐ Would you like to receive text messages?

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

### Section 3

Employment Status: ☐ Full Time ☐ Part Time ☐ RetiredStudent Status: ☐ Full Time ☐ Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyp.: \_\_\_\_\_

Additional Comments:

### Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient: ☐ 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: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

### Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient: ☐ 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: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_

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 ☐ N/A \_\_\_\_\_Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Have you ever had a serious head or neck injury? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Are you taking any medications, pills, or drugs? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Please list all of your medications \_\_\_\_\_  
\_\_\_\_\_Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Do you use tobacco? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Are you on a special diet? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Do you use controlled substances? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_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 ☐ Local Anesthetics ☐ Other \_\_\_\_\_

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

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pacemaker*      | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No ☐ N/A \_\_\_\_\_Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Condition may require medication N/A - Not answered by patient

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 \_\_\_\_\_

DATE \_\_\_\_\_

## *Financial Agreement*

This office is happy to cooperate with individuals who have dental insurance as a courtesy to you. Our office will file your claims with your primary, and sometimes secondary, insurance company. Your insurance company is under contract with you and/or your employer. We ask that you read your policy and understand all limitations of your benefits. Please call your insurance company or human resources department if you have questions. You are ultimately responsible for all costs related to your care.

1. If you **do not** have insurance, you will be expected to pay for services **in full** at the time of service.
2. Please bring your insurance card on the day of your appointment. If your insurance changes, **it is your responsibility to notify our office.**
3. We require you to pay your co-insurance and/or deductible amounts at the time of service.
4. After insurance benefits have been received, any unpaid balance must be paid within 30 days. Finance charges will accrue after 30 days.
5. We wait 60 days for insurance companies to pay. If your insurance company fails to pay, or rejects your claim, we ask that you pay the balance in full and seek reimbursement from them. We will assist you with the necessary paperwork.
6. A fee will be added to your account balance if collection proceedings are required.
7. It is our policy to take bitewing and panoramic/full mouth x-rays on **ALL** new patients unless you request and bring copies from your previous dentist, **REGARDLESS OF WHETHER YOUR INSURANCE WILL COVER OR NOT.** You may decline to have x-rays taken, but we may not be able to treat you without. Full Mouth X-rays are taken every three years.
8. Our office has a 24 hours notification policy. There will be a charge of \$50+ dollars on all missed appointments, without 24 hours notice.

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Your Signature

*Bradley D. Scott, D.D.S. 5151 E. Broadway, Ste 101, Mesa, Az. 85206*

*Bradley D. Scott, DDS*

## NOTICE OF PRIVACY PRACTICES

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.

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 Notice takes effect (04/14/03), 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 the 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 DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your 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 qualifications 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 for 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 an authorization, 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 your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up 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 written authorization.

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

**Abuse or Neglect:** 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 of 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

# Bradley D. Scott, DDS

## 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 a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.15 for each page, \$15.00D 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 an 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.

**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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## 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 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.

Contact Officer: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Address: \_\_\_\_\_