

Misty Horn - Blake, D.D.S.

[Insert Name of Practice]

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

SIGNATURE.

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

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welcome

Age _____ Date _____

Patient's Name _____ Date of Birth _____ Male Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
 Single Married Separated Divorced Widowed Minor

Residence - Street _____

City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance Cash Credit Card

Purpose of Call _____

Other Family Members in this Practice _____

Whom may we thank for this referral _____

Patient/parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

**DENTAL INSURANCE
1ST COVERAGE**

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

**DENTAL INSURANCE
2ND COVERAGE**

Employee Name _____ Date of Birth _____

Relationship to patient _____

Employer Name _____ Yrs. _____

Name of Insurance Co. _____

Address _____

Telephone _____

Program or policy # _____

Social Security No. _____

Union Local or Group _____

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE _____

REGISTRATION

welcome

PATIENT NUMBER

Patient's Name Last First Initial Nickname Date of Birth
Parent's Guardian's Name

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

- 1. Is this your child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist?
3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
4. Does your child eat between meals? YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. When does your child brush his/her teeth?
7. How does your child receive Fluoride?
8. Have any cavities been noted in the past? YES NO
9. Were any teeth (baby or permanent) removed by extraction? YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
11. Has your child had any problem with dental treatment in the past? YES NO
12. Has anyone in the family, including parents, had orthodontics? YES NO
13. Has your child ever received a local anesthetic? YES NO
14. Has your child ever had occlusal sealants? YES NO
15. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY

- 1. Does your child have a health problem? YES NO
2. Is your child under care of physician? YES NO
3. Name of physician Phone
4. Is your child receiving any medication? YES NO
5. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
6. Is your child allergic to or sensitive to any metals or latex? YES NO
7. Does your child have other allergies? YES NO
8. Has your child had any serious illness? YES NO
9. Has your child ever had surgery? YES NO
10. Does your child have a heart murmur? YES NO
11. Is surgery contemplated? YES NO
12. Does your child experience severe or prolonged bleeding? YES NO
13. Does your child have AIDS or has he/she tested HIV positive? YES NO
14. Has your child tested positive for hepatitis? YES NO
15. Is your child subject to nervous disorders? YES NO
16. Does your child have frequent headaches? YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

Large empty box for patient or guardian comments.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE DATE

DENTIST'S SIGNATURE DATE

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

Misty Horn-Blake, D.D.S.
BROKEN APPOINTMENT POLICY

Our goal is to provide our patients with the best dental care possible. We are aware that unavoidable situations can arise at the last minute which can make it impossible to keep appointments. Unfortunately, this situation is becoming an increasing problem for our office.

Our office makes routine calls and sends out reminder cards to our patients to confirm appointments. With patients so busy these days, it is very difficult for us to refill an appointment time on short notice. We have therefore been forced to establish an office policy, which requires a **48 business hour notice** for rescheduling or canceling an appointment. If two appointments are broken without 48-hour notice, we will charge a nominal fee of \$25.00 to reschedule.

Thank you for respecting our doctor's, staff and other patients' time by keeping this policy.

FOOD & BEVERAGE

We ask that no food or beverages be consumed in the waiting room and there is to be no smoking on the premises.

SMALL CHILDREN

For patients who have small children, we ask that prior arrangements be made with a sitter so that they will not have to wait for long periods of time during your appointments. Children are not allowed in the treatment rooms during the parent's appointment.

Sign _____ Date _____

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003, 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 applicable law permits the changes. 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 health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;