

PATIENT INFORMATION

Full Name _____
Last First Middle Preferred Name

Marital Status _____ Date of Birth _____ Age _____ Soc. Sec. # _____

Residence _____
Street City State Zip Code

Mailing Address _____
Street City State Zip Code

Email Address _____ May we send information to your email address? Yes No

Home # _____ Work # _____ Cell # _____ May we call at work? Yes No

Last dentist consulted _____ Referred to us by _____

In case of emergency, name & phone of person to be contacted _____

RESPONSIBLE PARTY INFORMATION (THIS SECTION TO BE COMPLETED IF PATIENT IS NOT RESPONSIBLE FOR PAYMENT)

Name _____

Mailing Address _____
Street City State Zip Code

How long at this address? _____ Home #: _____ Work #: _____ May we call at work? Yes No

Previous address (if less than 3 yrs.) _____

Soc. Sec. # _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ # of years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ # of years employed _____

Soc. Sec. # _____ Date of Birth _____ Work #: _____ May we call at work? Yes No

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Co. _____ Group # _____ Date of Birth _____

Insurance Co. Address _____ Phone # _____

Insured's Employer _____ Insured's ID # _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Co. _____ Group # _____ Date of Birth _____

Insurance Co. Address _____ Phone # _____

Insured's Employer _____ Insured's ID # _____



Release of benefits & information I authorize my insurance benefits to be paid directly to Harvard Dental Group. I am financially responsible for any balance due. I authorize Harvard Dental Group or the insurance company to release any information required for this claim. I understand that, where appropriate, credit bureau reports may be obtained. Even though an insurance claim is pending, I will receive a statement each month if my account has an outstanding balance. We will be happy to file your insurance claim, however, we cannot accept responsibility for collecting your insurance claim. The responsible party is obligated for payment in full on this account. In the event of non-payment, responsible party shall bear the cost of collection including, but not limited to, reasonable attorney's fees.

X Signature _____ **Date** _____

HARVARD DENTAL GROUP

**HARVARD DENTAL GROUP
MEDICAL HISTORY FORM**

Patient Name _____ Date _____

Please circle appropriate answer (leave blank if you don't understand the question)

- Yes No** Is your general health good?
Yes No Has there been a change in your health in the last year?
Yes No Are you under the care of a physician? If Yes, name & phone _____
If Yes, what is the condition being treated? _____
Date of last medical exam _____
Yes No Have you been hospitalized or had a serious illness in the last five (5) years?
If Yes, please explain _____
Yes No Have you had problems with prior dental treatment? Date of last dental exam _____
Yes No Are you in pain now? Describe _____

Are you taking, or have you ever taken bone/metastatic disease medication? Yes / No For how long? _____
_____ Zometa (Intravenous/IV) _____ Boniva _____ Actonel
_____ Aredia (Intravenous/IV) _____ Didronel _____ Fosamax
_____ Reclast (injection 1x/year)

Have you ever had, or currently have, the following: (circle Yes/No)

- | | | |
|-----------------------------------|---------------------------------------|---|
| Y N Cancer or Tumors | Y N Bleeding/Bruising Problems | Y N Depression |
| Y N Radiation Therapy | Y N Adrenal Disease | Y N Seizures/Epilepsy |
| Y N Heart Attack | Y N Thyroid Disease | Y N STD (Syphilis, Herpes or Gonorrhea) |
| Y N Heart Trouble | Y N Stroke | Y N HIV/AIDS |
| Y N Pacemaker | Y N Fainting/Dizziness | Y N Liver Disease/Hepatitis (Type _____) |
| Y N Prosthetic Heart Valve | Y N Kidney Disease | Y N Blood Transfusion |
| Y N Infective Endocarditis | Y N Artificial Joint | Y N Auto Immune Disorders |
| Y N Low Blood Pressure | Y N Arthritis | Y N Asthma |
| Y N High Blood Pressure | Y N Allergies/Sinus | Y N Tuberculosis, Emphysema or |
| Y N Frequent Headaches | Y N Stomach Ulcer | Other Lung Disease |
| Y N Diabetes (Type _____) | Y N Psychiatric Therapy | |

Yes No Allergies to drugs or latex? Please list _____

Yes No Are you taking any prescribed medications or over-the-counter medications? (incl. aspirin & natural remedies) Please list _____

Have you ever used:

- Yes No** Tobacco? (cigarettes, cigars, pipes, chewing tobacco)
How much per day? _____ For how long? _____ Quit date _____
Yes No Alcohol?
Yes No Recreational drugs?

Any disease, problem, or prolonged illness not listed on this form? Yes No
If Yes, please explain _____

Women Only

- Yes No** Birth control? Please list _____
Yes No Are you, or could you be pregnant? If Yes, how far along are you? _____
Yes No Are you nursing?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications.

X Signature _____ **Date** _____

Dentist Signature _____ Date _____ Hygienist Initials _____

Reviewed/Updated: _____ Date: _____ | _____ Date: _____
Signature *Signature*

Welcome to our office!



Our staff is committed to providing you with the very best possible care and, with your assistance and understanding, we can share a mutual respect that will lead to a long lasting relationship. In order to achieve this goal, we would like to make you aware of our payment policies. We make every effort to explain your treatment needs and costs to you up- front so that we can avoid any misunderstandings. If you have any questions, please do not hesitate to ask. We are here to serve you.

MISSED OR BROKEN APPOINTMENTS

Each appointment that is scheduled for you is a time that has been specifically reserved just for you. Therefore, if you need to change your appointment, kindly give us a 2-3 day notice so that your appointment time can be filled.

Anyone missing or cancelling an appointment with less than 24-hour notice will be subject to a \$25 charge per hour scheduled.

Exceptions may be considered in the event of illness or if the appointment time can be filled. If broken appointments become a chronic problem, we reserve the right to dismiss you from the office.

PATIENT FINANCIAL POLICY

- Payment is due at the time services are rendered unless payment arrangements have been approved by our staff. We accept cash, check, MasterCard, Visa, American Express, Discover and CareCredit. Emergency visits for all new patients must be paid in full unless dental insurance can be verified.
- Balances older than 90 days will be subject to interest charges. In the event payment is not made for services after a reasonable period of time, our attorney will be advised and formal action to collect will be initiated. You will be responsible for any attorney fees and/or collection expenses.
- Our staff will estimate your out-of-pocket expense for each visit and this amount will be due at the time of service. ALL CHARGES ARE YOUR RESPONSIBILITY AND MUST BE PAID WITHIN 90 DAYS FROM THE DATE SERVICES ARE RENDERED REGARDLESS OF INSURANCE.
- I authorize and direct payments of the dental benefits directly to Harvard Dental Group and consent to disclosure of my protected dental health information to carry out payment of benefits.

I have read, understood and accept the terms stated above.

X *Signature* _____ *Date* _____

Please see next page, which is yours to keep, and sign below to acknowledge receipt of the attached "NOTICE OF PRIVACY PRACTICES"

Print Name _____

X *Signature* _____

Date _____

FOR OFFICE USE ONLY

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

____ *Individual refused to sign acknowledgement form*

____ *Communication barrier prohibited obtaining acknowledgement*

____ *Emergency situation prevented obtaining acknowledgement*

You may refuse to sign this privacy acknowledgement.



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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2011, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. 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, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

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

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 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).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$0.25 for each page, \$25 per hour for staff time to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket 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.

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: 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 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: Brannick Adams, DDS
Telephone: 541-673-5150 Fax: 541-673-7044
E-mail: admin@harvarddentalgroup.com
Address: 1539 W. Harvard, Roseburg, OR 97471

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