Patient Registration

Date: *

First Name: * **Last Name: *** **Middle Initial:**

Patient is: * ○ Patient ○ Responsible party

Preferred Name: *

Patient Information

Address: *

City: * **State: *** **Zip Code: ***

Home Phone: * **Work Phone:** **Extension:** **Cellular: ***

Sex: * ○ Male ○ Female

Marital Status: * ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birthdate: * **Age: *** **Social Security: *** **Driver's License Number:**

Email: *

I would like to recieve correspondences vai e-mail: * ○ Yes ○ No

Please Confirm Email: *

Responsible Party (if someone other than the patient)

First Name: **Last Name:** **Middle Initial:** **Address:**

City: **State:** **Zip Code:** **Home Phone:** **Work Phone:**

Extension: **Cellular:** **Date of Birth:** **Social Security:** **Driver's License Number:**

Please Choose:

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

Section 2

Employment Status: *

◯ Full Time ◯ Part Time ◯ Retired

Student Status:

◯ Full Time ◯ Part Time

Preferred Dentist: **Preferred Pharmacy: *** **Preferred Hygienist:**

Section 3

Cell Phone: * **Emergency Contact: *** **Spouse Work Number:** **Mom Work Number:** **Dad Work Number:**

Primary Insurance Information

Name of Insured:

Relationship to Insured:

◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Social Security Number: **Date of Birth:**

Employer: **Work Address:**

City: **State:** **Zip Code:**

Insurance Company:

Insurance Company Address:

Insurance Company City: **Insurance Company State:** **Insurance Company Zip:**

Secondary Insurance Information

Name of Insured:

Relationship to Insured:
Self Spouse Child Other

Insured Social Security Number:

Date of Birth:

Employer:

Work Address:

City:

State:

Zip Code:

Insurance Company:

Insurance Company Address:

Insurance Company City:

Insurance Company State:

Insurance Company Zip:

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 important interrelationship with the dentistry you will reeceive. Thank you for answering the following questions.

Are you under a Physician's care now? *
Yes No

If yes, please explain

Have you ever 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 or drugs? *
Yes No

If yes, please explain

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? * **If yes, please explain**

Yes No

Do you use tobacco? * **If yes, please explain**

Yes No

Women:

Are you pregnant? * **If yes, please explain**

Yes No

Are you trying to get pregnant? *

Yes No

If yes, please explain

Are you nursing? * **If yes, please explain**

Yes No

Are you taking oral contraceptives? *

Yes No

If yes, please explain

Are you allergic to any of the following:

Aspirin * **If yes, please explain**

Yes No

Penicillin * **If yes, please explain**

Yes No

Codeine * **If yes, please explain**

Yes No

Local Anesthetics * **If yes, please explain**

Yes No

Metal * **If yes, please explain**

Yes No

Latex * **If yes, please explain**

Yes No

Sulfa Drugs * **If yes, please explain**

Yes No

Acrylic *
Yes No

If yes, please explain

Other known allergies:
Yes No

If yes, please explain

Do you use controlled substances? *
Yes No

If yes, please explain

Do you have or have you had any of the following:

	Yes	No
AIDS / HIV Positive		
Alzheimer's Disease		
Anaphylaxis		
Anemia		
Angina		
Arthritis / Gout		
Artificial heart Valve		
Artificial Joint		
Asthma		
Blood Disease		
Blood Transfusion		
Breathing Problem		
Bruise Easily		
Cancer		
Chemotherapy		
Chest Pains		
Cold Scores/Fever Blisters		
Congenital Heart Disorder		
Convulsions		

	Yes	No
Cortisone medicine		
Diabetes		
Drug Addiction		
easily Winded		
Emphysema		
Epilepsy or Seizures		
Excessive Bleeding		
Excessive Thirst		
Fainting Spells/Dizziness		
Frequent Cough		
Frequent Diarrhea		
Frequent headaches		
Genital Herpes		
Glaucoma		
Hay Fever		
Heart Attack/failure		
Heart Murmur		
Heart Pacemaker		
Heart trouble/Disease		

	Yes	No
Hemophilia		
Hepatitis A		
Hepatitis B or C		
Herpes		
High Blood Pressure		
high Cholesterol		
Hives or Rash		
Hypoglycemia		
Irregular Heartbeat		
Kidney Problems		
Leukemia		
liver Disease		
Low Blood Pressure		
Lung Disease		
Mitral Valve Prolapse		
Osteoporosis		
pain in Jaw joints		
Parathyroid Disease		
Psychiatric care		

	Yes	No
Radiation Treatments	○	○
Recent Weight Loss	○	○
Renal Dialysis	○	○
Rheumatic Fever	○	○
Rheumatism	○	○
Scarlet Fever	○	○
Shingles	○	○
Sickle Cell Disease	○	○
Sinus Trouble	○	○
Spina Bifida	○	○
Stomach/Intestinal Disease	○	○
Stroke	○	○
Swelling of Limbs	○	○
Thyroid Disease	○	○
Tonsillitis	○	○
Tuberculosis	○	○
Tumor or Growths	○	○
Ulcers	○	○
Venereal Disease	○	○
Yellow Jaundice	○	○

Have you ever had any serious illness not listed above ? *

Yes No

If yes, please explain

Comments:

To the best of my knowledge, the questions on this form have been accurately answeres. I understand that proving 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.

If there is anything else you would like us to know, please provide that information here:

Name of Patient, Parent, or Guardian:

Signature of Patient, Parent, or Guardian:

Date: *

April 14, 2003

THE NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As part of the federal Health Insurance portability and Accountability Act of 1996, known as HIPAA, Bloomington Family Dental, Ltd. (BFD) has created this Notice of Privacy Practice (Notice). This notice describes BFD's privacy practice and the rights you, the individual, have as they relate to the privacy of your Protected Health Information (PHI). Your PHI is information about you, or that could be used to identify you, as it relates to your past and present physical and mental health care services. The HIPPA regulation required BFD protect the privacy of your PHI that BFD has received or created.

BFD will abide by the terms presented within this Notice. For any uses or disclosures that are not listed below, BFD will obtain written authorization from you for that use or disclosure, which you will have the right to revoke at any time, as explained in more detail below. **BFD reserves the right to change BFD's privacy practice and this Notice.** Revision to the Notice will be posted in BFD and upon your request, provided to you in paper format.

HOW BFD MAY USE AND DISCLOSE YOUR PHI

The following is an accounting of the ways BFD is permitted, by law, to use and disclose your PHI.

Use and disclosures of PHI for treatment: We will use the PHI we receive from you to coordinate or manage your health care.

Use and disclosures of PHI for payment: BFD will disclose your PHI to obtain payment for reimbursement from you, insurers or third parties for your health care services.

Use and disclosures of PHI for Health Care Operations: BFD will use your PHI to conduct quality assessments, improves activities, and evaluate the BFD work force.

Optional: Appointment Reminders. BFD may disclose your PHI to conduct you and remind you of an appointment.

Optional: Treatment Options. BFD may use and disclose your PHI to inform you of potential treatment options and alternatives.

Optional: Health-Related Benefits and Services. BFD may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Optional: Release of Information to Family/Friends. BFD may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to pediatrician's office for treatment of a cold. In this example, the baby sitters may have access to the child's medical information.

The following is an accounting of additional ways in which BFD is permitted or required to use or disclose PHI about you without your written authorization.

Use and discloser as required by law: BFD is required to use or disclose PHI about you as required and as limited by law.

Use and discloser for Public Health Activities: BFD may use or disclose PHI about you to a public health authority by law to collect for the purpose of preventing or controlling disease, injury, or disability.

Use and discloser about victims of abuse, neglect or domestic violence: BFD may use or disclose PHI about you to a governmentauthority if it is reasonably believed you are a victim of abuse, neglect or domestic violence.

Use and discloser for health oversight activities: BFD may useor disclose PHI about you to health oversight activities that is authorized by law to conduct.

Disclosures for judicial and administrative proceedings: BFD may disclose PHI about you in the course of any judicial or administrative proceedings, provided proper documentation is presented to BFD.

Disclosures for law enforcement purposes:BFD may disclose PHI about you to law enforcements officials for authorized purposes.

Use and disclosures to avert a serious threat to health or safety:BFD may use or disclose PHI about you, if it believed in good faith, and is consistent with any applicable law and standards of ethical conduct, to avert a serious threat to health or safety.

Disclosures for worker's compensation:BFD may disclose PHI about you as authorized by and to the extent necessary to comply with workers' compensation laws or programs established by law.

Disclosures for disaster relief purposes:BFD may disclose PHI about you as authorized bylaw to a public or privateentity to assist in disaster relief efforts.

Disclosures for business associates:BFD may disclose PHI about you to BFD's business associates for services they may provide to or for BFD.

FOR ALL OTHER USES AND DISCLOSURES

BFD will obtain a written authorization from you all other uses and disclosures of PHI, and BFD will only use or disclose pursuant to such authorization. In addition, you may revoke such authorization in writing at any time. To revoke a previously authorized use or disclosure, please contact HIPAA Officer, 908 North Hershey, Suite 2, Bloomington Illinois 61704.

YOUR HEALTH INFORMATION RIGHTS

The following is a list of your rights in respects to your PHI.

The right to request confidential communications about your PHI: You have the right to request BFD communicate confidentially with you using an address or phone number other than your residence. However, state and federal laws require BFD to have an accurate address or phone number in case of emergencies. BFD will consider all reasonable requests. In order to request a type of confidential communication, you must make a written request to **HIPAA Officer 908 North Hershey, Suite 2, Bloomington, Illinois 61704** specifying the requested method of contact, or the location where you wish to be contacted. BFD will accommodate **reasonable** requests. You do not need to give a reason for your request.

The right to request restrictions on certain uses and disclosures of you PHI: You have the right to request a restriction in BFD's use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request BFD to restrict its disclosure of your PHI to only certain individuals involved in your health care or payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do not agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **HIPAA Officer, 908 North Hershey, Suite 2, Bloomington, Illinois 61704.** Your request must describe in a clear and concise fashion:

1. The information you wish restricted;
2. Whether you are requesting to limit BFD's use, disclosure or both; and
3. To whom you want the limits to apply.

The right to inspect and/or obtain a copy of your PHI: You have the right to inspect and obtain a copy of PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **HIPPA Officer, 908 North Hershey, Suite 2, Bloomington, Illinois 61704** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstance; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

The right to amend your PHI: You have the right to request an amendment of your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for BFD. To request an amendment, your request must be made in writing and submitted to **HIPAA Officer, 908 North Hershey, Suite 2, Bloomington, Illinois 61704.** You must provide us with a reason supporting your request for amendment. BFD will deny your request if you fail to submit your request (and the reason for supporting your request) in writing. Also, we may deny your request if you ask BFD to amend information that is in BFD's opinion: 1. Accurate and complete; 2. Not part of the PHI kept by our practice; 3. Not part of the PHI which you would be permitted to inspect and copy; or 4. Not created by our practice, unless the individual or entity creating the information is not available to amend the information.

The right to receive accounting of disclosures of your PHI: You have the right to receive an accounting of certain disclosures of your PHI made by the health care provider. In order to obtain an accounting of disclosures, you must submit your request in writing to **HIPAA Officer, 908 North Hershey, Suite 2, Bloomington, Illinois 61704.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but BFD may charge you for additional lists within the same 12-month period. BFD will notify you of the costs involved with additional requests, and you may withdraw your requests before you incur any costs.

The right to receive additional copies of BFD's Notice of Privacy Practices: You have the right to receive additional paper copies of this Notice, upon request, even if you initially agree to receive the Notice electronically. If you wish to receive a paper copy of this request, please ask a BFD workforce member and they will provide you with one.

REVISIONS TO THE NOTICE OF PRIVACY PRACTICES

BFD reserves the right to change and/or revise this Notice and make the new revised version applicable to all PHI received prior to its effective date. The revised Notice will be available upon request, to all individuals. BFD will also post the revised version of the Notice in BFD.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with BFD and/or to the Secretary of Health and Human Services, or their designee. If you wish to file a complaint with BFD, please contact our HIPAA Officer, 908 North Hershey, Suite 2, Bloomington, Illinois 61704. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**