Legends DENTAL
GEORGE JEDLICKA, DMD

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PATIENT INFORMATION

Patient Name: _____ Birth Date:_____
Last First MI Preferred Name

☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child

Social Security #:_____ Driver's License #:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Mailing Address: _____
Street City State Zip

Employer Name _____

Email: _____

Preferred way of contact: _____

Who may we thank for referring you?
☐ **Family/Friend name**:_____ ☐ **Internet** (search words?)_____ ☐ Other_____

Responsible Party : ☐ Self ☐ Spouse ☐ Parent Information

Responsible Party Name: _____ Birth Date:_____
Last First

☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child

Social Security #:_____ Driver's License #:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email:_____

Primary Insurance Information

Insurance Company: _____
ID Number/SSN: _____
Group: _____
Ins. Phone #_____
Address: _____
Street City State Zip
Subscriber Name: _____
Subscriber Birth Date:_____

Secondary Insurance Information

Insurance Company: _____
ID Number/SSN: _____
Group: _____
Ins. Phone #:_____
Address: _____
Street City State Zip
Subscriber Name: _____
Subscriber Birth Date:_____

Patient Name_____

Last First Initial

CIRCLE THE APPROPIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASTE WRITE <u>DON'T KNOW</u> ON THE LINE AFTER THE QUESTION.

1. Physician's Name_____
   Address_____
2. Are you under a Physician's care……YES NO
3. When was your last complete physical exam……_____
4. Are you taking any medications or substances……YES NO
5. Do you routinely take health related substances……YES NO
6. Are you allergic to any medications or substances……YES NO
7. Do you have any other allergies……YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?……YES NO
9. Are you sensitive to any metals or latex?……YES NO
10. Are you pregnant or suspect you may be?……YES NO
11. Do you use any birth control medications?……YES NO
12. Have you ever been treated for heart disease?……YES NO
13. Do you have a pacemaker or artificial heart valve implant?……YES NO
14. Have you ever had rheumatic fever?……YES NO
15. Are you aware of any heart murmers?……YES NO
16. Do you have high or low blood pressure? Circle one……YES NO
17. Have you ever had a serious illness or major surgery?……YES NO
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?……YES NO
19. Do you have inflammatory diseases, such as arthritis?……YES NO
20. Do you have artificial joints/prosthesis?……YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc?……YES NO
22. Have you ever bled excessively after being cut or injured?……YES NO
23. Do you have any stomach problems?……YES NO
24. Do you have any kidney problems?……YES NO
25. Do you have any liver problems?……YES NO
26. Are you diabetic?……YES NO
27. Do you have asthma?……YES NO
28. Do you have epilepsy or seizure disorders?……YES NO
29. Do you or have you had a venereal disease?……YES NO
30. Have you tested HIV positive?……YES NO
31. Do you have AIDS?……YES NO
32. Have you ever had or do you test positive for Hepatitis? A B or C.. ……YES NO
33. Do you or have you had T.B.?……YES NO
34. Do you smoke, chew, use snuff or any form of tobacco?……YES NO
35. Do you consume alcoholic beverages?……YES NO
36. Do you habitually use controlled substances?……YES NO
37. Have you had psychiatric treatment?……YES NO
38. Do you have any disease, condition, or problem not listed?……YES NO
39. Is there anything else we should know about your health that we have not covered in this form?_____

Comments

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT/GUARDIAN

SIGNATURE_____DATE_____

HIPAA Information and Consent Form

The Health Insurance Portability and Acountability Act (HIPAA) provides safeguards to protect your privacy, Implentation of HIPAA requirements officially began on April 14th, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions who may see or be notificed of your Protected Health Information (PHI). These resctrions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or ensure that all administrative matters related to your care are handled appropiately. This specificlly includes the sharing of informatin with other healthcare providers, laboratories, health insurance payers as is necessary and appropiate for your care. Patient fiels may be stored in open file racks and will not contain any coding which identifies a patients condition or informatio which is not already a matter of public record. The nornal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedues utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or requested by you. We may send you other communications informing you of changes to office policy and new technology that you may find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their record in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward

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OFFICE AND FINANCIAL POLICIES

INSURANCE: We will bill your insurance as a courtesy to you. Insurance is not a guarantee of payment. Deductibles and your estimated co-pays will be due at the time of treatment. You will be expected to pay for services rendered if the office is unable to verify your insurance before treatment. We will happily bill both primary and secondary insurance companies. However, if you do not present insurance information at the time services are rendered, you will be responsible for payment in full.

PATIENT PAYMENT: We accept cash, Visa, Mastercard, American Express, personal check, and CareCredit cards. Returned checks will have a $25.00 NSF added to the total payment due.

SERVICE CHARGE: If payment for services rendered has not been paid in full within 60 days either by you or your insurance company, you are responsible for payment. Account balances over 60 days will incur an 18% annual finance charge.

NO SHOW/MISSED APPOINTMENTS: We request notice of 24 hours for cancellation of appointments. We reserve the right to charge a $50.00 fee for missed appointments without sufficient notice. After the third missed appointment, we reserve the right to dismiss a patient/family from our practice. We understand that sometimes last minute cancellations are unavoidable; individual circumstances may be discussed with office coordinator.

CONSENT: I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I ahtoruze the consent that the doctor employ any such assistance as he/she seems appropriate. I further authorize the release of any information, including any diagnosis, radiographs and records of any treatment or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payments must be made before treatment begins.

I have read and understand the Office and Financial Policies. I have had the opportunity to ask any questions and I agree to comply with the policies. I certify to the best of my knowledge that all information I have been provided is accurate and true. By signing this agreement, you agree to pay for any costs we estimate due to us prior to services being provided.

PATIENT SIGNATURE: _____ DATE: _____