

Kuhn Dental Associates
Drs. Kuhn, Grimshaw, Kuhn & Dennison

GENERAL PATIENT INFORMATION

Patient Registration

Patient Information

Full Name: _____
Date of Birth: _____
Marital Status: Single Married Separated Divorced Widowed
Sex: Male Female
SSN/ID: _____
Email Address: _____
Home Phone Number: _____
Cell Phone Number: _____

Drivers License

State: _____
Number: _____

Home Address:

Address: _____
City, State and ZIP: _____

Billing Address:

Address: _____
City, State and ZIP: _____

Work Information

Employer: _____
Occupation: _____
Work Phone Number: _____

Method of Contact: Phone Email Text Message Any of the previous ones

Emergency Contact:

Full Name: _____
Phone Number: _____
Relation: _____

How did you hear about our office?

Who may we thank for referring you? _____

GENERAL PATIENT INFORMATION

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name: _____
SSN/ID: _____
Relation to Patient: _____

Patient's Student Status

Student Status: _____
College: _____
College Address: _____

Primary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____
Date of Birth: _____
SSN/ID: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: Individual Family Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

Secondary Dental Insurance Company – Subscriber and Insurance Company Details

Subscriber Name: _____
Date of Birth: _____
SSN/ID: _____
Employer: _____
Policy Number: _____
Group Number: _____
Coverage Type: Individual Family Prepaid / Capitation
Insurance Company: _____
Company Phone Number: _____
Company City, State, ZIP: _____

Pharmacy Information

Name: _____
Address: _____
Pharmacy Phone Number: _____

Medicaid Number: _____

I authorize the dentist to release any information, including diagnosis, treatment plans/records and radiographs to third party payers and/or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the dental group or dentist benefits that are, otherwise, payable to me. I understand that my dental insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this dental office, I accept responsibility and agree to be obligated to pay the office in accordance with its payment and credit terms and policies.

Signature: _____

PATIENT MEDICAL HISTORY

Patient's Medical History

Physician Information

Physician's Full Name: _____

Address: _____

City, State and ZIP: _____

Are you currently under a physician's Care? Yes No

If Yes, for what?

Have you been hospitalized in the last two years? Yes No

If Yes, for what?

Are you taking any medication, drugs or pills? Yes No

If so, please list the names and dosages of each:

Do you Smoke? Yes No How Much? _____

Women Only

Are you pregnant? Yes No What is your due date? _____

Are you nursing? Yes No Are you taking birth control pills? Yes No

Are you on Hormone Therapy? Yes No

Patient's Current or Previous Conditions

Select any of the following if you presently have or have had the condition in the past:

Medical Alerts

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergic to Penicillin | <input type="checkbox"/> Allergic to Codeine | <input type="checkbox"/> Pre-Medication required | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Allergic to Tetracycline | <input type="checkbox"/> Allergic to 'Novocaine' | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Allergic to Aspirin | <input type="checkbox"/> Allergic to Latex Rubber | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Prior Hepatitis |
| <input type="checkbox"/> Other | | | |

Medical Conditions

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Excessive Bleeding when Cut | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gastrointestinal Upset | <input type="checkbox"/> Artificial Joint Replacement |
| <input type="checkbox"/> Congenital Heart Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Extreme Nervousness |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis A or B | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Deep Vein Clot | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> HPV (Human Papillary Virus) |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Cortisone Treatment |
| | | | <input type="checkbox"/> Chemical Dependency |

Our office is unique and unlike any dental office you have ever been to. Your upcoming visit is an important first step toward getting the dentistry you seek. We place a high emphasis on helping you determine your present, as well as your future, dental needs, wants and desires. Here are some things we are going to be talking about at your first visit. These are some issues you may not have considered before. Please answer these questions in a way that best expresses how you feel. Your answers will help us to prepare for your visit so that we may better serve you.

1. Are you having any areas of concern? _____

2. What do you think is the current state you your mouth's health? _____

3. How healthy do you want us to get your mouth? (Check one)

Pain relief / repairs only

Average

The best it can be

4. Tell us about your last dental experiences _____

And the bad ones _____

5. Why did you leave your last dental office? _____

6. What about your smile would you like to improve? _____

7. What would it take for you to trust us to be your dentist? _____

8. Do you have any family or friends that already come to our office? Yes No

9. What do you already know about our office and what are your expectations? _____

10. Has fear ever been an issue for you in a dental office? Yes No

11. Our office specializes in providing sedation for anxious patients. We offer oral, I.V., and nitrous sedation. Would any of the following be of interest to you? Oral Sedation (pills) I.V. Sedation (twilight sedation) Nitrous Oxide

12. Has time ever been an issue for you in getting your dental work done? Yes No

13. Has the cost or dental treatment been a concern for you? Yes No If yes, what can we do to help you with this? _____

14. We have the unique ability to look at your mouth from three different perspectives. Which of these would you like us to use for you? (Please check all that apply.)

As a General Dentist

As a Cosmetic Dentist

As a Functional Dentist

15. At what point do you want to initiate treatment? (Please check one)

When my tooth hurts or breaks

When something is worsening

When it's not ideal

16. What quality of dentistry do you want us to recommend? Repairs Average Ideal/the best

17. What additional information would you like for us to know? _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Unless prior arrangements are made, payment is expected on the day of treatment.

All emergency dental services, or any dental service without prior financial arrangements, must be paid at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will be happy to assist in the filing of dental claims upon your request; however cannot render services on the assumption that our charges will be paid by an insurance company. Also, it is the patient's responsibility to provide accurate and complete insurance information if this office is to submit claims.

Fee estimates listed for dental treatment are only extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me at home or work to discuss matter related to this information.

Monthly Statements: If you have a balance owing on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any and any payments or credits applied to your account during the month.

Finance Charge: A finance charge will be imposed on any overdue balance on your account not in compliance with agreed payment agreement. The **FINANCE CHARGE** will be computed at the rate of two percent (2%) per month or an **ANNUAL PERCENTAGE RATE OF** twenty four (24%) percent. The finance charge is computed by applying the periodic rate (2%) to the "overdue balance" of your account. The minimum finance charge is \$5.00.

Returned Checks: There is a fee (currently \$25) for any checks returned by the bank.

Waiver of confidentiality: If your account is submitted to an attorney, collection agency or past due status is reported to a collection agency, the fact that you received treatment at our office may become a matter of public record.

Consent to Release/Review Dental information/Records: All patients have the right to expect that all communications and records pertaining to their care should be treated as confidential. So that you may make a thorough examination and diagnosis, I also understand that you may need to obtain information from my medical doctor and/or prior dentist(s). Therefore, I grant you the right to obtain records and information, including payment history, from my medical doctors and prior dentists. I also give you permission to share my health information with other health care professionals and dental specialists which would include the release of dental charts and records, including payment history. A duplication fee will be assessed (currently \$25), when records are transferred, payable at time of request.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent/guardian Date _____ Relationship to Patient _____

Signature of guarantor of payment Date _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Policies.

Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

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 (MM/DDNR), 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. *We will continue to use your protected health information in some of these specific ways: by calling you by your first and last name from our waiting room, by posting daily schedules in areas throughout our office and on computers, by mailing you a reminder appointment card with reason for visit, by calling to confirm appointments and leaving a message if necessary. By using photographs or slides of study cases when authorized, by having sedation patients sign sedation log when medication is dispensed, by continuing to allow patients access to front office area for use of telephone and when scheduling conferencing is required.*

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 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, xrays, 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 or 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).

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 \$1.- for each page, \$25 - 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.

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: Renate Yow
Telephone: (910) 692-4450/ (800) 682-4191
Fax: (910) 692-3919
E-mail: drkdmd@earthlink.net