HELENA FAMILY DENTISTRY

Patient Information Form

We are pleased to welcome you to our practice! Please take a few moments to fill out this form as completely as you can.

Name_____ Social Security # _____

(Provide patients name as it is shown on your insurance card) Preferred to be called_____

Address_____ How long at this address? _____

City_____ State _____ Zip _____ Home#_____ Cell_____

Sex: Male ____ Female____ Birthdate: _____ Email:

_____

Single ____ Married ____ Adult ____ Minor _____ Age: _____

Date of your last dental cleaning/visit _____

How did you hear about us? _____

Responsible Party Information

(This MUST be filled out completely)

Person Responsible for this account_____ Relation to Patient _____

Address _____ Home # _____

SSN # _____ DOB _____ Financial Institution _____

Employer _____ Work # _____

Is this person currently a patient in our office? Yes _____ No _____

Insurance Information

Insurance Provider: _____ Contract: _____ Group # _____

Name of Policy Holder _____ DOB _____

SSN# _____ Employer_____ _____

Home # _____ Cell # _____ Work # _____

Is this person currently a patient in our office? Yes ____ No ____

Secondary Information

Insurance Provider: _____ Contract: _____ Group # _____

Name of Policy Holder _____ DOB _____

SSN# _____ Employer_____ _____

Home # _____ Cell # _____ Work # _____

Is this person currently a patient in our office? Yes ____ No ____

I understand that Helena Family Dentistry reserves the right to charge a **$75.00** fee for any appointments cancelled or broken without **48 hours' notice**. We do try to confirm our appointments in advance as a courtesy to you, however, numbers change, messages go undelivered etc. **But, it is still the patient's responsibility to re-schedule their appointment or cancel on timely basis.**

Consent to contact patient/Guardian by cell phone I agree in order for us to service your account or to collect monies due, Helena Family Dentistry and/or agents may contact you by telephone at any telephone number associated with your account, including wireless numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.
I/We have read this disclosure and agree that Helena Family Dentistry, its employees, and/or agents may contact me as described above.

Patient/Guardian Signature _____ Date _____

Helena Family Dentistry

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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,

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

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

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Consent for Services

I hereby give Dr. Stacey DeFranco and staff my consent to perform any dental procedures they deem necessary or advisable with my permission. I agree to allow Dr. DeFranco and staff to administer a local anesthetic or a nitrous oxide and oxygen analgesic, depending on his professional judgment after consulting with me. I understand there are no guarantees on the work that is completed by Dr. Stacey DeFranco. In the event of any dental emergency, I agree to allow Dr. DeFranco and staff to administer all necessary treatment.

When treatment plans are presented, I understand that the expected insurance payment is an estimate only. If for any reason the insurance company should not pay the estimated amount, I will be responsible for the difference. I further acknowledge that I am familiar with my dental policy and understand that Dr. DeFranco is filing my insurance only as a courtesy to me. I also agree to pay any balance that is outstanding for 60 days or on my account even if I have insurance and awaiting payment by them. When the insurance company submits payment, Dr. DeFranco will then reimburse me of any overpayment on the account.

In order to set up and account in this office, I agree that all accounts will be charged interest at a rate of 6% per month and a $10.00 per month statement fee for any account owed after 60 days for the date of treatment.

I will be responsible for all charges incurred by me. Should collection action become necessary, I agree to pay all costs of collections, including a reasonable attorney's fee, and waive all rights to claim personal property exempt under the laws of the State of Alabama. I understand and authorize all dishonored checks plus a processing fee to be electronically debited from my account.

We do try to confirm all appointments in advance as a courtesy to you, however, numbers change, messages go undelivered, emergencies happen, etc, but it is still the patient's responsibility to re-schedule their appointment or cancel in a timely manner.

I understand that Helena Family Dentistry reserves the right to charge a $75.00 fee for any appointment cancelled or broken without a 48 hour notice.

Non Covered Services Policy

As your dentist, I want to provide you with your choice of dental services. There may be certain services that you select that may not be covered by your insurance company. Sometimes there is a difference in our fee and the fee that the insurance company will allow for a certain procedure. You will be expected to pay the fee schedule difference for that service or pay the service in full. For example, your contract may only pay for amalgam (silver) fillings in back teeth when a composite (tooth colored) filling is used. In addition, procedures that are considered for payment are not always paid in full by your insurance company; therefore the patient shall be responsible for the remaining balance. Let me reassure you that only services necessary and appropriate for your treatment and care will be performed. If you have any questions or concerns, someone in our office will be happy to assist you.

I have read your policy and agree, as indicated by my signature below, to pay for the services that are not covered or for which payment is not allowed by my insurance company.

_____ _____

Patient/Guardian Signature Date

PRIVACY NOTICE

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

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

• To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);

• To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);

• To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;

• Internally, to all staff members who have any role in your treatment;

• To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;

• To your family and close friends involved in your treatment; and/or,

• We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

• Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

• Request restrictions on the use and disclosure of your protected health information;

• Request confidential communication of your protected health information;

• Inspect and obtain copies of your protected health information through asking us;

• Amend or modify your protected health information in certain circumstances;

• Receive an accounting of certain disclosures made by us of your protected health information; and,

• You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

• By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;

• To abide by the terms of our Privacy Notice that is currently in effect;

• To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised

Please note that we are not obligated to:

• Honor any request by you to restrict the use or disclosure of your protected health information;

• Amend your protected health information if, for example, it is accurate and complete; or,

• Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

• This privacy notice is effective as of the date of your signature. If you have any questions about the information in this

Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PRIVACY CONSENT

- Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, social security numbers, and demographic data)may be used in connection with your treatment, payment of our account or health care operations (i.e., performance reviews, certification, accreditation and licensure).
- You have the right to review our office's privacy notice prior to signing this Consent, a copy of which was given to you with this Consent.
- You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.
- We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.
- You may revoke this Consent at any time in writing. However, such revocation will be effective to the extent that any action has been taken in reliance on this Consent

Thank you for your cooperation. Please let us know if you have any questions.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____ _____

Patient/Guardian Date

PRIVACY AUTHORIZATION

This Authorization is required by the privacy regulations recently promulgated by the United States Department Of Health and Human Services. Your protected health information such as demographic date, photographs, x-rays, and study models may be used or disclosed for the purpose of lectures/presentations, publications, research, and/or practice marketing. This information will be disclosed by the following people: Dr. DeFranco. This Authorization will not expire. You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on. If your Treatment will be used for research purposes, we may condition your treatment on obtaining this Authorization, in which case you may not receive treatment. The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient(s) and thus, no longer protected by the privacy rules.

_____ _____

Patient/Guardian Signature Print Name

_____

Date