Registration

DALE FAMILY DENTISTRY
Caring for You...and Your Smile!

Kenneth G. Dale, DDS
2241 State Street, Suite C
New Albany, IN 47150
812-945-5100 (Tel) • 812-945-5101 (Fax)
www.DaleFamilyDentistry.com
info@DaleFamilyDentistry.com

Patient Information

Name ____________ ____ ____________
First MI Last

How do you wish to be addressed? ____________

Today's Date: ________ Birthdate: ________ Age: ______

Social Security #: ____________ Sex: ☐M ☐F

Residence: Street ____________

City ____________ State ______ Zip ______

Employer: ____________ Occupation: ____________

Check appropriate box:

☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

If Student, School's Name ____________

School's City: ____________ Full time? ☐Yes ☐No

Whom may we thank for referring you? / How did you learn of our office?

____

Have you seen Dr. Dale before? ☐Yes ☐No

Previous Dentist: ____________

Telephone & Contact

Home Phone : ____________ Cell Phone: ____________

Work Phone : ____________ Dept./Ext.: ______

E-mail address: ____________

Responsible Party Telephone Numbers (if different):

Home Phone : ____________ Work Phone : ____________

Where do you prefer to receive phone calls?

☐Home ☐Work ☐Cell Phone ☐Please do not call at Work

In the event of an Emergency, who should we contact?

Name : ____________ Relationship : ____________

Home Phone : ____________ Work Phone : ____________

Responsible Party

Responsible Party for Payment of this Account: ☐Same as Patient

Name ____________ ____ ____________
First MI Last

Relationship to Patient: ____________

Birthdate: ____________ Social Security #: ____________

Residence: Street ____________

City ____________ State ______ Zip ______

Employer: ____________ Occupation: ____________

Is the Responsible Party a Patient in our Office? ☐Yes ☐No
☐No, but will be

Dental Insurance

Do you have dental insurance? ☐Yes ☐No

If Yes, please continue...

Name of Insured (Policy Holder): ____________

Relationship to Patient: ____________

Insured's Birthdate: ____________

Insured's Social Security #: ____________

Employer: ____________

Employer's Address: ____________

Insurance Company: ____________

Insurance Co. Address: ____________

Insurance Co. Phone #: ____________

Group #: ____________ Employee ID #: ____________

Do you have any additional Insurance? ☐Yes ☐No If Yes, continue...

2nd Policy Holder Name: ____________

2nd Policy Holder Birthdate: ________ Social Security #: ________

2nd Policy Holder Employer: ____________

2nd Insurance Co. Name: ____________

Authorization & Payment

◆ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. ◆ I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. ◆ I authorize and request my insurance company to pay directly to the dentist Insurance benefits otherwise payable to me. ◆ I understand that my dental insurance carrier may pay less than the actual bill for services. ◆ I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. ◆ I agree to pay collection costs and reasonable attorney fees in attempting to collect on this account or any future outstanding account balances. ◆ Interest charges (1½%/mo.,18% APR) may be applied to my past due account and there is a $15 fee for a returned check which I agree to pay. ◆ We do expect payment in full (less any estimated insurance) at each appointment, unless alternative financial arrangements are made. ◆ For your convenience, you may make a financial arrangement for your portion due by selecting one of our established financial options. Please ask for details of our extended payment plans. ◆ A $40 missed appointment fee may apply; see our appointment policy for full details.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

X ____________________________ ____________
Signature of Patient or Parent if Minor Date

Revised 09/2009

NOTICE OF PRIVACY PRACTICES

For the office of

DALE FAMILY DENTISTRY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW ACCESS TO THIS INFORMATION MAY BE ATTAINED.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. The law also requires us to give you this notice about our policy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practice and the terms of this notice at any time, provided such applicable law permits the changes. 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 at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician, or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations includes quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing, or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses of disclosure 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 describe in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your dental information based on our professional judgment or weather the disclosure would be in your best interest. We may use our professional judgment on whether the disclosure would be in your best interest. We may 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 prescriptions, medical supplies, x-rays, or similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location, or of your general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefits: We may use or disclose your health information as authorized by law for the following purposes deemed to be in the public interest or benefit, as required by law: for public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury; to report adult abuse, neglect, or domestic violence; to health oversight agencies, in response to court and administrative orders and other lawful processes; to law enforcement officials pursuant to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to coroners; medical examiners; and funeral directors; to an organ procurement organization; to avert a serious threat to health or safety; in connection with certain research activities; to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities; to correctional institutions regarding inmates; and as authorized by state worker's compensation laws.

Access: You have the right to look at copies or 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. 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 may- but are not required to- 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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003.) That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional request. Contact us using the information listed at the end of this notice for more information about fees.

Restrictions: 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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on your behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation of how you will handle payment 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 wiring, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you believe we have violated your privacy rights, we incorrectly made a decision about access to your health information, our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or we should communicate with you by alternative means or at an alternative location, you may contact us using the information listed below. You may also submit a written complaint to 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.

Dental Office: Dale Family Dentistry, Kenneth G. Dale, D.D.S.
Contact: Privacy Officer
Telephone Number: 812-945-5100
Fax Number: 812-945-5101
E-Mail: info@dalefamilydentistry.com
Address: 2241 State St., Suite C, New Albany, IN 47150

For the office of **DALE FAMILY DENTISTRY**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
and
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT FOR WHOM CONSENT IS BEING GIVEN

Patient's Name: ____

SECTION B: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form below, I acknowledge that I have received a ***Notice of Privacy Practices*** from Dale Family Dentistry.

SECTION C: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact: Dale Family Dentistry, Kenneth G. Dale, D.D.S., c/o Privacy Officer
Telephone Number: (812) 945-5100 Fax Number: (812) 945-5101
Address: 2241 State Street, Suite C, New Albany, IN 47150
E-Mail: info@dalefamilydentistry.com

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ______________________________ Date: ______________________________
Patient (Responsible Party, if Minor)

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
You May Refuse to Sign This Acknowledgement

Time 8:29 AM

Dale Family Dentistry

Date 3/31/2017

Current Medical History 2016

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

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
Are you taking any prescription medications?	◌ Yes ◌ No	If yes
Do you smoke, chew, use snuff or other tobacco?	◌ Yes ◌ No	If yes
Have you ever had a serious head or neck injury?	◌ Yes ◌ No	If yes
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 allergies? ◌ Yes ◌ No If yes

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

AIDS/HIV Positive	◌ Yes ◌ No	Anemia	◌ Yes ◌ No	Arthritis/Gout	◌ Yes ◌ No	Artificial Heart Valve	◌ Yes ◌ No
Artificial Joint	◌ Yes ◌ No	Asthma	◌ Yes ◌ No	Blood Transfusion	◌ Yes ◌ No	Bruise Easily	◌ Yes ◌ No
Cancer	◌ Yes ◌ No	Chemotherapy	◌ Yes ◌ No	Cold Sores/Fever Blister	◌ Yes ◌ No	Congenital Heart Disorder	◌ Yes ◌ No
Diabetes	◌ Yes ◌ No	Drug Addiction	◌ Yes ◌ No	Emphysema	◌ Yes ◌ No	Epilepsy or Seizures	◌ Yes ◌ No
Frequent Headaches	◌ Yes ◌ No	Glaucoma	◌ Yes ◌ No	Hay Fever	◌ Yes ◌ No	Heart Attack/Failure	◌ Yes ◌ No
Heart Murmur	◌ Yes ◌ No	Heart Pacemaker	◌ Yes ◌ No	Heart Surgery	◌ Yes ◌ No	Heart Pacemaker	◌ Yes ◌ No
Hemophilia	◌ Yes ◌ No	Hepatitis A	◌ Yes ◌ No	Hepatitis B or C	◌ Yes ◌ No	High Blood Pressure	◌ Yes ◌ No
Kidney Problems	◌ Yes ◌ No	Liver Disease	◌ Yes ◌ No	Mitral Valve Prolapse	◌ Yes ◌ No	Pain in Jaw Joints	◌ Yes ◌ No
Psychiatric Care	◌ Yes ◌ No	Radiation Treatments	◌ Yes ◌ No	Rheumatic Fever	◌ Yes ◌ No	Sinus Trouble	◌ Yes ◌ No
Stroke	◌ Yes ◌ No	Thyroid Disease	◌ Yes ◌ No	Tuberculosis	◌ Yes ◌ No	Ulcers	◌ Yes ◌ No

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

Do your gums bleed while brushing or flossing?	◌ Yes ◌ No
Are your teeth sensitive to hot or cold liquids/foods?	◌ Yes ◌ No
Are your teeth sensitive to sweet or sour liquids/foods?	◌ Yes ◌ No
Do you feel pain in any of your teeth?	◌ Yes ◌ No
Do you have any clicking, pain or difficulty opening or closing your jaw?	◌ Yes ◌ No
Do you clinch or grind your teeth?	◌ Yes ◌ No
Have you had any periodontal (gum) treatments?	◌ Yes ◌ No
Are you interested in improving the appearance of your teeth?	◌ Yes ◌ No
Are you apprehensive about dental treatment?	◌ Yes ◌ No

Comments (include Physician's name and phone number):

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:__________