Registration

About You

Patient Name:_____ SS#_____-_____-_____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____Cell Phone:_____

Sex: Male ____ Female ____ Date of Birth ____/____/_____ Single ___ Married ___ Separated ___ Divorced ___

Employer Name: _____ Address: _____

Occupation: _____ E-mail: _____

Spouse's Name: _____ Spouse's Employer: _____

Who may we thank for referring you? _____

For Our Insured Patients

Primary Subscriber Name: _____ SS# ____-____-____ DOB: ___/___/___

Address: _____ City:_____ State:_____ Zip:_____

Employer: _____ Address: _____

Insurance Company: _____ Group Number: _____

Is there a secondary insurance? If so complete the following:

Subscriber's Name: _____ SS# _____-_____-_____

Date of Birth: _____ Insurance Company: _____

Group Number: _____

I authorize release of any information regarding my treatment to my insurance company.

_____ _____

(Patient or Subscriber (if Present)) Date

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Reason for today's visit:

_____

_____

Previous Dentist/Date of last visit: _____

DENTAL INFORMATION

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have a burning/numbness sensation on tongue, lip, cheek?	YES	NO
Do you have clicking or popping jaw?	YES	NO
Do you have sensitivity when biting?	YES	NO
Do you have any loose teeth or broken fillings?	YES	NO
Do you experience mouth pain while brushing?	YES	NO
Do you have pain around ear?	YES	NO
Do you have swollen/tender gums?	YES	NO
Do you have sensitivity to sweets?	YES	NO
Do you have jaw pain?	YES	NO
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 to any of your teeth?	YES	NO
Do you have any sores or lumps in or near your mouth?	YES	NO
Have you had any head, neck or jaw injuries?	YES	NO

Have you ever experienced any of the following problems with your jaw?

Clicking, Pain (joint, ear, side of face), Difficulty in opening or closing, Difficulty in chewing

Do you have frequent headaches?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you bite your lips or cheeks frequently?	YES	NO
Have you noticed any loosening of your teeth?	YES	NO
Does food tend to become caught between your teeth?	YES	NO
Have you ever had periodontal treatment (gums)?	YES	NO
Have you ever worn a bite plate or other appliance?	YES	NO
Do you wear dentures or partials?	YES	NO

If yes, date of placement: _____

Have you ever received oral hygiene instruction in regard to the care of your teeth and gums? YES NO

If you could change anything about your smile, what would you change?

_____

On a scale of 1-10 how would you rate your smile? *1 2 3 4 5 6 7 8 9 10*

HEALTH HISTORY

Patient's Name: _____Date:_____

*Place a mark on "**Yes**" or "**No**" to indicate if you have had any of the following:*

Anemia	□Y □N	Kidney Disease	□Y □N
Arthritis, Rheumatism	□Y □N	Liver Disease	□Y □N
Artificial Heart Valves	□Y □N	Low Blood Pressure	□Y □N
Artificial Joints	□Y □N	Mitral Valve Prolapse	□Y □N
Asthma	□Y □N	Pacemaker	□Y □N
Back Problems	□Y □N	Psychiatric Care	□Y □N
Bleeding abnormally, with		Radiation Treatment	□Y □N
extractions or surgery	□Y □N	Respiratory Disease	□Y □N
Blood Disease	□Y □N	Rheumatic Fever	□Y □N
Cancer	□Y □N	Scarlet Fever	□Y □N
Chemical Dependency	□Y □N	Shortness of breath	□Y □N
Chemotherapy	□Y □N	Sinus Trouble	□Y □N
Circulatory Problems	□Y □N	Skin Rash	□Y □N
Cortisone Treatment	□Y □N	Stroke	□Y □N
Cough, persistent or bloody	□Y □N	Swelling, Feet/Ankles	□Y □N
Diabetes	□Y □N	Swollen Neck Glands	□Y □N
Emphysema	□Y □N	Thyroid Problems	□Y □N
Epilepsy	□Y □N	Tuberculosis	□Y □N
Fainting or dizziness	□Y □N	Tumor or growth on	
Glaucoma	□Y □N	head or neck	□Y □N
Headaches	□Y □N	Stomach ulcer	□Y □N
Heart Murmur	□Y □N	Venereal Disease	□Y □N
Heart Problems	□Y □N	Weight Loss,	
Hepatitis Type_____	□Y □N	unexplained	□Y □N
Herpes	□Y □N	*Women:*	
High Blood Pressure	□Y □N	Are you pregnant?	□Y □N
HIV Positive	□Y □N	Due date_____	
Jaundice	□Y □N	Are you nursing?	□Y □N

Other medical information, not listed above?

_____
_____
_____
_____
_____

List medications you are currently taking:

_____
_____
_____
_____
_____

Allergies:

□Aspirin
□Barbiturates(sleeping pills)
□Penicillin
□Codeine
□Sulfa
□Tetracycline
□Latex
□Erythromycin
□Other _____
_____
_____

Physician's Name: _____**Phone#:**_____

Thank you for providing us this important information

Health History Update

Returning patients, has there been any change in your health since your last visit?
If so, what has changed?

_____
_____
_____

New medications?

_____
_____

_____ _____
(Patient Signature) (Date)

Written Financial Policy

Thank you for choosing Pursel Dental P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. _____

Payment Options:

- Visa
- MasterCard
- Discover Card
- Cash
- Check
- CareCredit
  - No Interest
  - Payment Plans
  - No Annual Fees
  - No Pre-Payment Penalties _____

Please Note:

Our practice requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. A finance charge of 1.5% monthly will be added to all accounts over 30 days, and a monthly cost of rebilling/account maintenance charge of $10.00 per service and date, unless previously written financial arrangements are satisfied. If any account balance should remain unpaid for an additional 60 days, the account is referred to a collection agency. You agree to pay the costs of collection and any fees and costs that may be added to the account balance. Once an account has been referred to collections, no one listed on that account will be eligible for any future services. We will be happy to forward any and all records to any other dental care provider. _____

For patients with dental insurance we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment. _____
*However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

A fee of $25.00 is charged for patients who miss or cancel more than two times without 24 hour notice. _____

There is a $25.00 fee for returned checks. _____

If you have any questions please do not hesitate to ask. We establish trusting and caring relationships with our clients, with the ultimate goal of preventing disease and preserving health. We provide comprehensive healthcare dentistry in a cosmetic style. _____

Patient, Parent, or Guardian Signature Date

Patient Name (Please Print)

Consent for Services

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

The doctor(s) and staff of Pursel Dental, P.C. are authorized to treat the Patient named in the Patient Information and to exchange past, present, and future medical information with the patient's other caregivers for the purpose of enhancing and promoting the continuity of care for the patient.

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.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash, check, or credit card at the time services are performed.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full on all accounts, regardless of what my dental benefit plan pays. This office will help prepare my insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. ***However, this dental office cannot render services on the assumption that any charges will be paid by an insurance company.***

I understand my dental benefit program is a contract between me, the employer, and the insurance company; The dentists are not a party to that contract. Not all benefits are covered benefits in all contracts, therefore, I agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full. It is my responsibility to know my contract, and any questions about my contract should be directed to the employer. Any co-payment is expected at the time that services are rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, **and a Monthly cost of rebilling/Account Maintenance charge of $10.00** per service **and date,** unless previously written financial arrangements are satisfied. If any account balance should remain unpaid for an additional 60 days, and the account is referred to a collection agency I agree to pay the costs of collection and that such fees and costs may be added to the account balance.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the dentist, I agree to pay the reasonable value of said services to said dentist, or his assignee, at the time services are rendered. I further agree that the reasonable value of services shall be as billed unless objected to, by me, in writing, within 30 days.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

_____Date:_____ Relationship to Patient:_____

Signature of guarantor of payment/responsible party

PURSEL DENTAL P.C.
www.purseldental.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBBS HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION:

PLEASE READ CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "H1PAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose you medical records only for each of the following purposes: Treatment, Payment and health care operations.

• TREATMENT means providing, coordination or managing health care and related services by one or more health care providers; an example of this would include cleaning services.

• PAYMENT means ;such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, post-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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 and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 16,2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to` change the terms of our Notice of privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices for this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the Provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA call tool free: 1-877-696-6775

Patient Name (print): _____Signature: _____Date: _____