



PATIENT INFORMATION (Confidential)

Patient's Name: _____ Sex: Male Female
Status: Minor or Student Single Married Divorced Widowed
Birthdate: ____/____/____ Social Sec. #: _____ Driver's Lic. #: _____
Address: _____ City: _____ State: _____ Zip Code: _____
E-mail: _____ I would like to receive correspondence via e-mail Yes No
Home Phone: (____) _____ Cell Phone: (____) _____
Patient's Employer: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip Code: _____
Work Phone: (____) _____ Ext. _____ May we contact you at work? Yes No
Spouse/Parent's Name: _____
Spouse/Parent's Employer: _____ Work Phone: (____) _____ Ext. _____
Person to Contact in Case of Emergency: _____ Phone: (____) _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY (if other than patient)

Person Responsible on Account: _____ Relationship to Patient: _____
Social Sec. #: _____ Birthdate: ____/____/____ Home Phone: (____) _____
Address: _____ City: _____ State: _____ Zip Code: _____
Employer: _____ Work Phone: (____) _____ Ext. _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Copayments are expected at each appointment. Cash Check Credit/Debit Card (Mastercard, Visa, Discover or American Express) Financing (thru Capital One)

INSURANCE INFORMATION

Dental Insurance Company: _____ Policy No./SS#: _____ Group No: _____
Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____
Insured's Employer: _____ Work Phone: _____ Ext. _____

DO YOU HAVE A SECONDARY DENTAL INSURANCE? Yes No (IF "YES", COMPLETE THE FOLLOWING.)

Secondary Dental Insurance Co: _____ Policy No./SS#: _____ Group No: _____
Name of Insured: _____ Relationship to Patient: _____ Birthdate: ____/____/____
Insured's Employer: _____ Work Phone: (____) _____ Ext. _____

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand payment is due in full when services are rendered. I understand this office is not a provider of my insurance and insurance may pay less than the actual bill of services. I authorize this office to bill my insurance and send any information needed to process my dental claim by mail, fax and/or by e-mail.

Signature: _____ Date: _____

Relationship (if signed by authorized agent of Patient): _____



MEDICAL HISTORY
(Confidential)

Staci R. Blaha, D.D.S

Patient Name: _____ Date: _____

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 questions.

If you answer "yes" to any questions below, please specify:

- Are you under a physician's care now? Yes No _____
- Have you ever been hospitalized or had a major operation? Yes No _____
- Have you ever had a serious head or neck injury? Yes No _____
- Please list any medications, pills or drugs that you take? Yes No _____
- Do you take, or have you taken, Phen-Fen, Redux, Bisphosphonates? Yes No _____
- Do you need to premedicate? Yes No _____
- Do you have a tobacco addiction? Yes No _____
- Do you use controlled substances? Yes No _____

WOMEN: Are you Pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
- Sulfa Drugs Barbiturates Sedatives Iodine Other _____

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

<input type="checkbox"/> AIDS/HIV Positive	<input type="checkbox"/> Congenital Heart Disorder	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> Mitral Valve Prolapse*	<input type="checkbox"/> Swelling of Limbs
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Heart Murmur*	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Pacemaker*	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Angina	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Heart Trouble/Disease	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Easily Winded	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Radiation Treatments	<input type="checkbox"/> Tumors or Growths
<input type="checkbox"/> Artificial Heart Valve*	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Herpes	<input type="checkbox"/> Rheumatic Fever*	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Tobacco Addiction
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Fainting Spells/Dizziness	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Surgery
<input type="checkbox"/> Breathing Problem	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Sensitive Teeth/Gums	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Sickle Cell Disease	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Sinus Trouble	* Condition may require medication
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Spina Bifida	
<input type="checkbox"/> Cold Sores/Fever Blisters		<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stomach/Intestinal Disease	
		<input type="checkbox"/> Low Blood Pressure		

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

How often do you brush? _____ Floss? _____

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 _____

DATE _____

Doctor Comments: _____

Doctor Signature: _____ Date: _____



Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of use of your health information for TREATMENT PURPOSES:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for PAYMENT PURPOSES:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of use of your health information for HEALTH CARE OPERATIONS:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request in writing to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will **not** include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact the **Office Manager, Shelley Kincaid, 816-858-2027**, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

OUR RESPONSIBILITIES

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the **Office Manager, Shelley Kincaid, 816-858-2027**.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Shelley Kincaid, 2204 Kentucky Avenue, Platte City, MO 64079**. You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is **601 E. 12th St. Room 248, Kansas City MO 64106**.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

OTHER DISCLOSURES AND USES

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication With Family

Using our best judgement, we may disclose to a family member, or other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: **January 1, 2007**

I, _____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Name

Date

Financial Agreement

Payments:

- Payment is due at the time of service
- We accept Cash, Personal Checks, Visa/MasterCard/Discover
- 5% Courtesy Savings for a full Cash/Check payment on the day of service (\$800 or more)
- 3% Courtesy Savings for a full Credit Card payment on the day of service (\$800 or more)
* Photo Identification required

Emergency Dental Services:

- Any/all emergency dental services must be **PAID IN FULL by CASH or CREDIT CARD** the time services are performed.
* Photo Identification required

Insurance:

- Patients who carry dental insurance understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment.
- Claim amounts not covered by the insurance company are the responsibility of the patient.
- Co-Pay percentage estimates are due at the time of service.
- In order to file insurance claims we require complete employer and insurance information. Inability to file claims due to incomplete information will result in the treatment payment in full at the time of service.
- Insurance claims not settled by your insurance company within 45 days of submission will need to be handled promptly. It is the patients' responsibility to follow up with their insurance carrier to determine the reason for the delay.
- Insurance companies that send payments directly to the patient will be required to pay for the entire treatment at the time of service. Platte Valley Dental Care will file the claim for the patient.

Service Charges:

- A finance charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days regardless of insurance status.
- You are responsible for all fees associated with the collection of debt for professional services provided to this patient by Platte Valley Dental Care including but not limited to collections costs, finance charges, court and attorney fees.

Minor Patients:

- The adult accompanying a minor on the day of service and the parent(s)/legal guardian(s) are responsible for full payments.

Patient Name (Please Print)

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 payment and agree to their content.

Signature guarantor of payment/responsible party Date: _____ Relationship to Patient: _____