PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ (LAST) _____ (FIRST) _____ (MI) Mr. Mrs. Ms. Dr. (CIRCLE ONE)

Address: _____ (NUMBER & STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

(_____) _____ (HOME PHONE) (_____) _____ (WORK PHONE) (_____) _____ (CELL PHONE)

M F (SEX) _____ (MARITAL: M D S W) _____/_____/_____ (DOB) _____ (SOCIAL SECURITY NUMBER) _____ (EMAIL ADDRESS)

_____ (OCCUPATION) _____ (EMPLOYER) FULL TIME PART TIME (CIRCLE ONE)

INSURANCE INFORMATION

Employer: _____ (COMPANY NAME) _____ (ADDRESS – NUMBER & STREET)

Address: _____ (CITY) _____ (STATE) _____ (ZIP) (_____) _____ (EMPLOYER PHONE)

_____ (GROUP NUMBER) _____ (ID NUMBER)

_____ (INSURANCE COMPANY NAME) _____ (INSURANCE COMPANY ADDRESS – NUMBER & STREET)

_____ (CITY) _____ (STATE) _____ (ZIP) (_____) _____ (INSURANCE PHONE)

RESPONSIBLE PARTY INFORMATION

_____ (RESPONSIBLE PARTY OCCUPATION) _____ (EMPLOYER) FULL TIME PART TIME (CIRCLE ONE)

Name: _____ (LAST) _____ (FIRST) _____ (MI) Mr. Mrs. Ms. Dr. (CIRCLE ONE)

Address: _____ (NUMBER & STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

(_____) _____ (HOME PHONE) (_____) _____ (WORK PHONE) _____ (EXT) _____ (SOCIAL SECURITY NUMBER) M F (SEX) _____ (BIRTHDAY)

ADDITIONAL INFORMATION

Spouse: _____ (FIRST NAME) _____ (MI) _____/_____/_____ (DOB) _____ (SOCIAL SECURITY NUMBER) (_____) _____ (WORK PHONE)

_____ (SPOUSE'S OCCUPATION) _____ (EMPLOYER)

AUTHORIZATION AND RELEASE: I authorize Dentistry with TLC to release any information, including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such dental care, to third party payers and/or healthcare practitioners. I authorize Dentistry with TLC to evaluate my credit record through any credit reporting agencies. I authorize and request my insurance company to pay directly to the dentist or dental group dental benefits otherwise payable to me. I understand that my 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 my dependents. All accounts that are past 30 days will be subject to a 1.5% monthly finance charge (18% yearly), plus all cost of collections, if necessary.

Signature: _____ Date: _____

Patient Evaluation Form

1. How did you hear about our practice?
   - ❑ Referred by a friend
   - ❑ Directory of dentists provided by my insurance company
   - ❑ I saw one of your advertisements
   - ❑ Walk by or drove by the practice

2. Date of your last hygiene visit: _____

3. On a scale of 1 to 5 *(1 being bad, 5 being good)* please rate how you feel your overall dental health is.

   1 2 3 4 5

4. On a scale of 1 to 5 *(1 being bad, 5 being faithful)* Over the last ten years rate how faithfully you have had your teeth cleaned?

   1 2 3 4 5

5. On a scale of 1 to 5 *(1 being not sensitive, 5 being very sensitive)* what is you're level of sensitivity to dental procedures?

   1 2 3 4 5

6. On a scale of 1 to 5 *(1 being not sensitive, 5 being very sensitive)* what is your sensitivity to cleaning visits?

   1 2 3 4 5

7. Rate how you feel about your smile and the look of your teeth. *(1 being unhappy, 5 being very happy.)*

   1 2 3 4 5

8. Are you interested in regular hygiene cleanings?
   - ❑ Yes ❑ No

9. What is the main reason for your visit today?
   - ❑ Tooth pain
   - ❑ I need to check up
   - ❑ Cleaning
   - ❑ Orthodontics (braces)
   - ❑ Whitening
   - ❑ Cosmetic dentistry
   - ❑ Sedation dentistry
   - ❑ Other _____

10. I would like to learn more about?
    - ❑ Orthodontics
    - ❑ Whitening
    - ❑ Cosmetic dentistry
    - ❑ Sedation dentistry
    - ❑ Implants
    - ❑ Bridges
    - ❑ Veneers
    - ❑ Dentures
    - ❑ Other _____

HEALTH HISTORY

Name _____ Date _____ Date of Birth _____

Mailing Address _____ City _____ State_____ ZIP_____ Phone _____

Are you allergic or have you had a reaction to:

a. Local anesthetics ..... No Yes
b. Penicillin or other antibiotics ..... No Yes
c. Aspirin, Ibuprofen or Tylenol ..... No Yes
d. Codeine, Valium® or other sedatives..... No Yes
e. Latex or Metals..... No Yes
f. Other (please specify)_____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form?	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma?	No	Yes	Kidney Disease?	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease? (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes?	No	Yes
Diabetes?	No	Yes	Psychosis?	No	Yes
Emphysema or other Respiratory/Lung Illnesses?	No	Yes	Previous Biopsies?	No	Yes
Epilepsy?	No	Yes	Radiation or Chemotherapy Treatment?	No	Yes
Fainting or Dizzy Spells?	No	Yes	Rheumatic Fever?	No	Yes
Glaucoma?	No	Yes	Slow-Healing Mouth Sores?	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis?	No	Yes	Unintentional Weight Loss/Gain?	No	Yes
Heart Valve (artificial) or Heart Transplant?	No	Yes	H.I.V. Infection/AIDS or ARC?	No	Yes
Congenital Heart Disease?	No	Yes	Venereal Disease?	No	Yes
Heart Disease, Heart Attack, Heart Surgery?	No	Yes	Other Conditions?	No	Yes
Heart Stent? When Placed?	No	Yes	Sleep Apnea?	No	Yes
Stop Breathing During Sleep?	No	Yes	CPAP Therapy?	No	Yes
Restless Sleep?	No	Yes	Gasping During Sleep?	No	Yes
Snoring?	No	Yes	Have you ever used Botox?	No	Yes
			Have you ever used Dermal Fillers?	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Abnormal Blood Pressure? (Please circle) No Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? S /D Today: _____/_____

Date of last health care exam: _____What was this exam for?_____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:_____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

How did you hear about Dentistry With TLC? _____

What is the persons name who referred you to Dentistry With TLC? _____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

DOCTOR'S USE ONLY

Existing prostheses and date of service:

_____

_____

Comments on patient interview concerning medical history and dental management considerations:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of changes in my health and medication at the beginning of all my future appointments at Dentistry With TLC.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

_____ _____

Doctor Signature *Date*

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Dentistry With TLC & Fastbraces ®
1317 D'Adrian Professional Park
Godfrey, IL 62035
618-466-0733

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Jayna Allen	618-466-0733	jayna@dentistrywithtlc.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Dentistry With TLC & Fastbraces® Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print)	Patient's Date of Birth
Signature of Patient or Parent/Legal Guardian	Date

APPOINTMENT GUDIELINES

Due to the fact that time is reserved especially for each individual patient's needs, your commitment to come on time to your appointment is essential. We are now requiring a 48 business hour cancellation notification. There will be absolutely no charge for your need to reschedule an appointment, provided we receive a 48 business hour notice. This courtesy will provide us with the opportunity to give this time to a patient who is waiting. The fee for cancellations with less than a 48 business hour notice is a minimum of $50 and a maximum equivalent to the cost of the visit. This fee will also apply to patients arriving more than 14 minutes late for a scheduled appointment. Thank you for your cooperation. We look forward to serving you.

Patient Name (Type or Print)	Date
Signature	