Welcome to Allied Dental Group

PATIENT INFORMATION:

Date: _____ Social Security Number:_____ Birthdate: _____

Name: (First, Last): _____ Home Phone:_____

Address: _____ Cell Phone:_____

City:_____ State:_____ Zip:_____ Email:_____

Sex: ☐ Male ☐ Female Who should we thank for referring you? _____

In case of emergency, who should we contact: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION:

***If the patient is a minor, the below information needs to be for the adult responsible for the account. Please leave blank if the information is the same as above.**

Person Responsible for Account: _____ Relationship to Patient: _____

Date of Birth: _____ Phone: _____ Social Security Number: _____

***If this patient resides in a group home, nursing home, and/or facility please complete the following:**

Facility Name: _____ Phone Number:_____

Point of contact for facilty:_____

DENTAL INSURANCE INFORMATION:

Primary Policy Holder: _____ Date of Birth: _____ Employer: _____

Social Security Number: _____ Insurance Company:_____

ADDITIONAL INSURANCE INFORMATION:

Primary Policy Holder: _____ Date of Birth: _____ Employer: _____

Social Security Number: _____ Insurance Company:_____

DENTAL HISTORY INFORMATION:

***If you are being referred to our practice from another dentist, please list their information below.**

Dentist Name: _____ City, State: _____ Phone:_____

Date of Last Visit: _____ Date of last X-rays:_____

MEDICAL HEALTH HISTORY:

Physician's Name: _____ City, State: _____ Phone:_____

Date of Last Visit: _____

Additional Physician's Information: _____

_____

MEDICAL HISTORY:

1. Are you currently under medical treatment? (If yes, List the treatment): _____
2. Have you ever had any serious illnesses or operations? (If yes, please list): _____
3. List ALL medications you are currently taking: _____

_____

Do you smoke/Use smokeless Tobacco? ☐ YES ☐ NO Do you use alcohol? ☐ YES ☐ NO Do you use any recreational drugs? ☐ YES ☐ NO

Do you wear contacts? ☐ YES ☐ NO Have you ever had a negative reaction to local anesthetic? ☐ YES ☐ NO

Have you ever been required to take antibiotics as a pre-medication prior to your dental appointments for **MEDICAL** reasons? ☐ YES ☐NO

Have you had any allergic reactions to the following?

☐ Antibiotics : _____ (List medication) ☐ Sulfa Drugs ☐Barbiturates ☐ Sedatives ☐ Iodine ☐Aspirin

☐ Latex ☐ Other: _____

(Women Only) Are you: ☐ Pregnant? ☐ Nursing? ☐ Taking Birth Control?

Please check all that apply:

☐ADHD ☐AIDS ☐Anemia ☐Arthritis ☐Artificial Heart Valves ☐Artificial Joints ☐Asthma ☐Autism

☐Bleeding Abnormally with Extractions ☐Blood Disease ☐Cancer ☐Cerebral Palsy ☐Chemical Dependency ☐Chemotherapy

☐Chronic Fatigue Syndrome ☐Circulatory Problems ☐Congenital Heart Lesions ☐Cortisone Treatments ☐Persistent Cough

☐Developmental Disability ☐Diabetes ☐Down Syndrome ☐Emphysema ☐Epilepsy ☐Glaucoma ☐Constant Headaches

☐Heart Murmur ☐Heart Problems ☐Hepatitis Type: _____ ☐Herpes ☐High Blood Pressure ☐HIV Positive ☐Jaundice

☐Kidney Disease ☐Liver Disease ☐Low Blood Pressure ☐Mental Health or Emotional Disability: _____

☐Mitral Valve Prolapse ☐Nervous Problems ☐Pacemaker ☐Physical Disability: _____ ☐ Psychiatric Care

☐Radiation Treatment ☐Respiratory Disease ☐Rheumatic Fever ☐Scarlet Fever ☐Sinus Issues ☐Skin Rash ☐Stroke

☐Swelling of Feet/Ankles/Neck ☐Thyroid Problems ☐Tonsillitis ☐Tuberculosis ☐Tumor on Head/Neck ☐Ulcer ☐Venereal Diseases

☐Other: _____

CANCELLATION POLICY:

To be respectful of the providers and the other patients of our practice **we require 24 hours notice to cancel or reschedule any appointment**. The office makes every attempt to contact you as a courtesy to remind you of your appointment. We kindly ask that you return any messages left by the office to confirm you will be at your scheduled appointment. Unfortunately, if you do not give the proper notice when canceling or rescheduling your appointment we will have no choice but to dismiss you from the practice. Your time is valuable to us and we hope ours is valuable to you. We strive to provide comprehensive quality care and we cannot do that if appointments are not kept.

ASSIGNMENT AND RELEASE/FINANCIAL AGREEMENT:

I hereby authorize payment directly to Allied Dental Group for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the office to release the information requires to secure payment of these benefits. I authorize the use of this signature on all insurance claims submitted. . **EFF 2/1/2016 Balances over forty five (45) days from the statement date will be assessed a $10 late charge per month, not to exceed the original balance.**

Signature: _____ Date: _____

ALLIED DENTAL GROUP HIPAA AUTHORIZATION FORM

Patient's Full Name _____ **Patient's Date of Birth** _____

☐ **Check this box if requesting that information not be released to anyone.**

I hereby authorize use or disclosure of protected health information about me or my child(ren) as described below.

1. I authorize the release of information including the diagnosis, records, and examination rendered to me and claims information to the following person (s):

_____
Spouse / Significant Other

_____
Children

_____
Other

2. Any specific information that should not be disclosed is (be specific):

_____

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3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Allied Dental Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for _____.

This release will remain in effect until terminated by the patient in writing.

**** FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility requires 48 hours to make copies and a signed release.**

_____	_____	_____
Signature of Patient*	**Date of Individual's Signature**	**Patient's Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Relationship to Patient**

Allied Dental Group, Ltd.

234 South Main St.

Slippery Rock, PA 16057 (724) 794-2224

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice: Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You: The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment: We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization:

- As required during an investigation by law enforcement agencies.
- To avert a serious threat to public health or safety.
- As required by military command authorities for their medical records.
- To workers' compensation or similar programs for processing of claims.
- In response to a legal proceeding.
- To a coroner or medical examiner for identification of a body.
- If an inmate, to the correctional institution or law enforcement official.
- As required by the US Food and Drug Administration (FDA).
- Other healthcare providers' treatment activities.
- Other covered entities' and providers' payment activities.
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA).
- Uses and disclosures required by law.
- Uses and disclosures in domestic violence or neglect situations.
- Health oversight activities.
- Other public health activities.

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.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization . If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved on your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment of it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would amendment, you have the right to file a statement of disagreement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer that six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12 –month period will be free. For addition lists, we reserve the right to charge you for the cost of providing the list.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes To This Notice: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future.

I HAVE RECEIVED THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES WRITTEN IN PLAIN LANGUAGE. THE NOTICE PROVIDES IN DETAIL THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MAY BE USED BY THIS PRACTICE, MY INDIVIDUAL RIGHTS, HOW I MAY EXERCISE THESE RIGHTS, AND THE PRACTICE'S LEGAL DUTIES WITH RESPECT TO MY INFORMATION. I UNDERSTAND THAT THIS PRACTICE RESERVES THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES, AND TO MAKE CHANGES REGARDING ALL PROTECTED HEALTH INFORMATION RESIDENT AT, OR CONTROLLED BY, THIS PRACTICE. I UNDERSTAND THAT I CAN OBTAIN THIS PRACTICE'S CURRENT NOTICE OF PRIVACY PRACTICES ON REQUEST.

SIGNATURE:_____

DATE:_____

RELATIONSHIP TO PATIENT (IF SIGNED BY A PERSONAL REPRESENTATIVE OR GUARDIAN:_____