Premier
Family Dentistry

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	AGE	SEX	DATE OF BIRTH
SOCIAL SECURITY NUMBER	DRIVER LICENSE NUMBER	EMPLOYER			
HOME ADDRESS	CITY	STATE	ZIP CODE		
HOME NUMBER ( )	WORK NUMBER ( )	CELL PHONE NUMBER ( )			
EMAIL ADDRESS					

Would you like to sign up for email/text reminders about upcoming appointments, specials or promotions?
If yes, please indicate the best method of contact? _____

DENTAL INSURANCE INFORMATION

If you do not have dental insurance please initial here. _____

POLICY HOLDER INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
HOME ADDRESS		CITY	STATE	ZIP CODE
EMPLOYER NAME		EMPLOYER PHONE NUMBER ( )		
EMPLOYER ADDRESS		CITY	STATE	ZIP CODE
INSURANCE COMPANY NAME		INSURANCE COMPANY PHONE NUMBER ( )		
INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
GROUP NAME	GROUP NUMBER	MEMBER/PROVIDER ID		

RESPONSIBLE PARTY INFORMATION

Is the responsible party the same as the patient information above? YES / NO
If you answered no, please fill out the information below.

LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME NUMBER ( )	WORK NUMBER ( )	CELL PHONE NUMBER ( )	DRIVER LICENSE NUMBER	
EMAIL ADDRESS:				

I certify the above information is accurate to the best of my knowledge. I understand if any of my information changes, it is my responsibility to notify Premier Family Dentistry immediately.

_____ _____

Patient Signature **Date**

(Parent/Guardian signature is patient is a minor)

_____

STAFF INITIALS

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 receive. Thank you for answering the following questions.

	YES	NO	If yes, please explain:
Are you currently under physician's care?	☐	☐	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Are you taking any medications, pills, or drugs?	☐	☐	
Do you take or have you taken Phen-Fen or Redux?	☐	☐	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐	
Are you on a special diet?	☐	☐	
Do you use tobacco?	☐	☐	
Do you use controlled substances?	☐	☐	
Do you have to premedicate for appointments?	☐	☐	

Women are you?

Pregnant/Trying to get pregnant? YES ☐ NO ☐ Taking Oral Contraceptives? YES ☐ NO ☐ Nursing? YES ☐ NO ☐

Are you allergic to any of the following?							
☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Local Anesthetics	☐ Acrylic	☐ Metal	☐ Latex	☐ Sulfa Drugs
☐ Other	If yes, please explain:						

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radition Treatment	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Breathing Problems	☐	☐	Frequent Headache	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsilitis	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
									Yellow Jaundice	☐	☐

Have you ever had any serious illness not listed above? YES ☐ NO ☐ If yes, please explain

Comments: _____

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 _____

_____

STAFF INITIALS

FINANCIAL POLICY AND AGREEMENT

Thank you for support by allowing us to provide your dental care. Below is our billing procedure and our financial policy. If you have any questions, please do not hesitate to contact our office.

_____ (INITIAL HERE) **1.** **Payment is due at the time services are rendered,** unless financial arrangements have been made with the financial coordinator. Appropriate methods of payment include: cash, check, credit cards (most credit cards are accepted) and care credit.

- **a. Emergency appointments must pay in full for dental services via cash or credit card.**
- **b. Returned checks are subject to a $30 NSF fee. If a check is returned, a personal check will no longer** be allowed as an acceptable form of payment from the patient.

_____ (INITIAL HERE) **2.** **Insurance** should be viewed as an aid in helping make dental treatment affordable. Dental insurance does not generally pay 100% of services. Patients are subject to deductibles and/or co-payment as set for by their insurance company. Insurance plan benefits and payment percentages are decreasing and the amount due from the patient is increasing. Secondary insurance plans are no longer guaranteed due to a clause called "non-duplication of benefits."

- **a. Please bring your insurance card** and any insurance information you have. This will allow us to assist with estimates for services rendered.
- **b. Co-payments and deductibles are due on the date of service.** We will estimate (or predetermine on larger cases) the co-payment amount and make payment arrangements prior to treatment. Pretreatment estimates by the insurance company are not a guarantee of payment and the patient is responsible for any unpaid balances.
- **c. We will file primary and secondary insurance claims only as a courtesy.** We will follow up on delayed claims up to 60 days after the date of service. After 60 days, the remaining balance is the responsibility of the patient.

_____ (INITIAL HERE) **3.** **Appointments** are scheduled for patients to allow for the best dental experience possible. While we understand that at times you may have to cancel or reschedule an appointment, please give us **at least a 24-48 hour notice** to allow other patients take your reservation time. For larger cases, we request a **48-72 hour notice** for appointment cancellations. Any patient that breaks an appointment within **24 hours is subject to a $35 cancellation fee per hour reserved for the patient**.

_____ (INITIAL HERE) **4.** **Express prior consent to contact consumer by cell phone:** You agree, in order for us to service your account or to collect monies you may owe, Premier Family Dentistry and/or our agents may contact you by telephone at telephone numbers associated with your account, including wireless telephone, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us to use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing devices, as applicable.

I hereby agree that all dental bills are due and payable upon receipt. Should my account become delinquent and require the services of a collection agency, I agree to pay any fees associated with collecting the debt, including collection agency fees (33.33%) and court costs. I also waive the rights of exemption under the constitution of the laws of Alabama or any other state as to personal property. All accounts must be paid in full within 90 days to avoid collection procedures.

I HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY:

PRINT PATIENT NAME

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

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STAFF INITIALS

NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

- The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires 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. "HIPAA" provides penalties for covered entities that misuse personal health information.
- As require 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 your medical records only for each of the following purposes: treatment, payment, and health care operations.
    - **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth 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, cost-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 submitting a written request.
    - The right to request restriction 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 communication of protected health information from us by alternative means or 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.

PRINT PATIENT NAME

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

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STAFF INITIALS

Notice of Nondiscrimination

Premier Family Dentistry of Alabaster, P.C.

Complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Premier Family Dentistry of Alabaster, P.C.

Does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Premier Family Dentistry of Alabaster, P.C.:

- Provides free aids and services in a timely manner to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - qualified interpreters
    - information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Premier Family Dentistry of Alabaster, P.C., Compliance Coordinator, 9200 Highway 119, Suite 200, Alabaster, AL 35007, Attn: Compliance Coordinator, (205) 621-5304, (205) 621-5306 (fax), premierfamily@yahoo.com (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal.jsf, or by mail or phone at: U.S. Department of Health and Human Service, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

_____ Please initial that you have received a copy of this form.

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STAFF INITIALS

Foreign Language Assistance

- **Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (205) 621.5304.
- **Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電(205) 621.5304。
- **Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (205) 621.5304 번으로 전화해 주십시오.
- **Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (205) 621.5304.
- **Arabic:** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (205) 621.5304
- **German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (205) 621.5304.
- **French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (205) 621.5304.
- **Gujarati:** સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (205) 621.5304.
- **Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (205) 621.5304.
- **Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (205) 621.5304पर कॉल करें।
- **Laotian:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (205) 621.5304.
- **Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (205) 621.5304.
- **Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (205) 621.5304.
- **Turkish:** DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. (205) 621.5304 irtibat numaralarını arayın.
- **Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(205) 621.5304 まで、お電話にてご連絡ください。

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STAFF INITIALS