



ABOUT YOU			
First Name: Middle	Initial: Last:		☐ Male ☐ Female
Birth Date: / Age: SSN	N:	☐ Single ☐ Ma	arried \square Divorced
Home Address:	City:	State: _	Zip:
E-mail:	For Apt. Reminde	rs: 🗆 Call: H / C / W	☐ Text ☐ Email
Phone Number: () Employer: _		Occupation:	
Employers Address:	City:	State: _	Zip:
Emergency Contact:	Relation	ship to Patient:	
Address:	PI	hone: ()	
Responsible Party			
Name:	_ Relationship to Pati	ent:	
SSN: Birth Date: /	/ Phone: (_)	_
Employer:	Work Phone: _		ext:
Insurance / Self Pay			
Self Pay: ☐ Cash ☐ Credit Card ☐ Care Credit Dri	ver's License #:		
Primary Dental Insurance Co.:	ID:	Group #: _	
Phone: () Address:	City:	State: _	Zip:
Policy Holder's Name: Relationship to Pa	atient: SS	SN: D0	OB: / /
Secondary Dental Insurance Company:		Group #: _	
Phone: () Address:	City:	State: _	Zip:
Policy Holder's Name: Relationship to Pa	atient: SS	SN: D0	OB: / /
Policy Holder's Employer:	Addı	ress:	
How did you hear about our office? ☐ Facebook ☐ Yellov	v Pages □ Website □	Friend 🗆 Location/Si	gn
□ Doctor □			
*** Whom may we thank for referring you?			

1219 St. Joseph Street, Rapid City, SD 57701 | 605-721-1219 | www.AndersonDentalDDS.com

Dental History Are you currently in pain? ☐ Yes ☐ No **Do you have any of the following concerns?** Bleeding Gums ☐ Hot/Cold Sensitivity ☐ Sensitivity to Sweets☐ Painful Biting Your dental concerns? _____ Use anything in addition to your brush & floss? \(\subseteq\ Y \subseteq\ N\) If yes, what? Do you suffer from dental anxiety? ☐ Yes ☐ No **Do you require antibiotics before treatment?** Yes No Are you happy with your smile? ☐ Yes ☐ No Due to: Artificial Joints Infective Endocarditis What would you like to change? ☐☐ History of infection in heart valve Have you experienced jaw pain or discomfort? ☐Yes ☐No Other: Date of last dentist visit: __/__/___ **Medical History** Are you currently under the care of a Physician? ☐ Yes ☐ No Are you <u>allergic</u> to any of the following? If yes, please explain: ☐ ☐ Antibiotics ☐ ☐ Jewelry/Metals Physician's Name_____ List all ☐ ☐ Latex Address: _____ Phone # Date of last visit / / ☐ ☐ Sedatives ☐ ☐ Barbiturates ☐ ☐ Codeine For Women: ☐ ☐ Dental Anesthetics ☐ ☐ Lactose Are you taking birth control pills? ☐ Yes ☐ No Please list additional allergies _____ Are you pregnant? ☐ Unsure ☐ Yes ☐ No Week# Are you Nursing? ☐ Yes ☐ No Are you taking any of the following medications / drugs? Yes No Yes No Yes No Yes No ☐☐Acetaminophen (Tylenol) ☐☐Blood Thinners ☐☐ Insulin /Diabetic drugs ☐ Steroids / Cortisone □□Blood Pressure Med ☐ Antibiotics □□ Naproxen (Aleve) ☐☐ Thyroid Medicine ☐ Antihistamines ☐☐Digitalis/Heart med ☐☐ Recreational Drugs ☐☐ Tranquilizers ☐ ☐ Antidepressants □□ Ibuprofen □□ Nitroglycerin □ Bisphosphonates, □ Aspirin □□ Other bone medications or shots (please list all medications) Do you or have you experienced the following? ΥN ΥN ΥN ΥN ☐☐ Abnormal Bleeding ☐ ☐ Chemotherapy □□ Heart Attack ☐ Migraines ☐☐ Sinus Problems ☐☐ Acid Reflux/GERD ☐ ☐ Colitis Oral Herpes/Cold Sore Smoke/ Chew/ Vape ☐☐ Heart Murmur ☐☐ Alcohol Abuse ☐ Congenital Heart Defect ☐ Heart Surgery □□ Pacemaker ☐☐ Steroid Therapy ☐☐ Anemia □□ Diabetes ☐☐ Hemophilia ☐☐ Psychiatric Problems ☐☐ Stroke ☐☐ Arthritis ☐☐ Difficulty Breathing ☐☐ Hepatitis Radiation Treatment ☐☐ Tonsillitis ☐☐ Tuberculosis (TB) ☐☐ Asthma ☐☐ Drug Abuse ☐☐HIV+/Aids ☐ Seasonal Allergies ☐☐ Blood pressure high ☐ Epilepsy ☐ Joint replacement ☐ Seizures ☐☐ Ulcers ☐☐ Blood pressure low ☐ ☐ Fainting Spells ☐☐ Kidney Problem ☐☐ Sickle Cell Disease Recent Surgeries (please list) ☐☐ Blood Transfusion ☐ ☐ Fever blisters ☐☐ Liver Disease Cancer_____ Frequent Headaches ☐ ☐ Lupus

Authorizations

I affirm that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am ultimately responsible for payment of services rendered and for payment of any co-pay and deductible that my insurance does not cover.

Signature:	Date:	

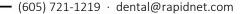


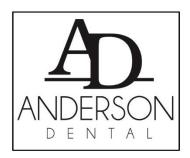
ANDERSON DENTAL

PAYMENT POLICIES, RESPONSIBILITIES & SIGNATURE ON FILE

Thank you for choosing Anderson Dental. Our mission is to deliver the finest, most cost effective dental treatment available. Following your exam, the doctor will advise you of a plan for treatment.

require payment prior to the beginning		fees as they are today. We
	esy for the patient. Insurance co-payments ments rests with the patient. The patient u	
PAYMENT OPTIONS THAT WE Cash/Check - Visa/MasterCard/Discov	OFFER: er - Care Credit Financing (ask for application) - I	Pre-payment Option
A charge of \$30 will be applied to	accounts for any returned checks.	
of 24-48 hours prior to any appointment I made and completed within reasonable tin	OLICY: unt of time is saved for all my appointments and i will be paying a \$50 broken appointment charge. ne the charge will be reimbursed toward the treatr n our practice for numerous appointments broken	If a second appointment is ment. Anderson Dental
values as follow (If treatment is not cor	e completed I understand that I will be paying a propertied pre-treatment deposit will be forfeited.) \$500 of treatment a \$100 deposit - Over \$1000 of treatment at least 2 days prior to treatment.	_
diagnostic aids deemed appropriate to ma and designated staff to perform all recomprofessional assistance as required provid necessary. I fully understand that using ar complete recital of any possible complica The undersigned hereby authorizes myself and/or dependents. I further expredentist to submit claims or benefits, for seevery claim to be submitted for myself an undersigned had personally signed the paroffice of any changes which affect the about	ntal and designated staff to take x-rays, study mod ke a thorough diagnosis. Upon such diagnosis, I a mended treatment mutually agreed upon by me an ing proper care. I agree to the use of anesthetics an esthetic agents embodies certain risks. I understattions. I the release of any information relating to all clair saly agree and acknowledge that my signature on the revices rendered or to be rendered without obtaining d/or dependents and that I will be bound by this signature claim. I understand that it is my responsible to the information. I also have read and understand the	uthorize Anderson Dental d to employ such and other medication as and that I can ask for a ms for benefits on behalf of this document authorizes my ag my signature on each and ignature as though the ility to inform the dental he broken appointment
these policies.	all of my questions answered regarding these issu	ies and agree to ablue by
Patient Name (PRINTED)	Date	
Patient Signature	Parent/Responsible Party Signature	Relationship to Patient





HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The Notices contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information or treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practices does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

We will be contacting you to confirm appointments. Phone Call / Email / Text Messag	ge. Which	option is best?	CIRCLE ONE	
May we leave a message on your answering machine at home or on your cell phone?	YES	NO		
May we discuss your medical condition with any member of your family?		NO		
If YES, please name the members allowed:				
This consent was signed by:				
(PLEASE PRINT NAME)				
Signature: Date:_				
Witness:				

NOTICE OF PRIVACY PRACTICIES (DENTAL)

Note: This Notice of privacy practices is provided for educational and informational purposes only. 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.

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used of disclosed by us in any form, electronically, on paper or orally, be kept properly confidential. This Act gives you, the patient, significant new rights to understand how your health information is used. 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 professional teeth cleaning services.
- **Payment** mean such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collecting activities, and utilization review. An example of this would be sending a claim 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 and customer service. AN example would be an internal quality assessment review.

We may also create and distribute non-identifiable 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 interest you. Any other uses and disclosures will be made only with your written 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 restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the
 information is required for treatment, payment or health care options.
- The right to receive confidential communications regarding our protected health information.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and 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.

We reserve the right to change the terms of this Notice. The policies in any new notices will not be in effect until they are posted within and available at our office.

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to this office. You will not be retaliated against in any manner for a complaint.

I understand that, under the Health Insurance Portability & Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name	Relationship to Patient
Signature	Date

For further information about our privacy policies, please contact our office at Anderson Dental, 1219 St. Joseph St., Rapid City, SD 57701. Tel: 605-721-1219.