(605) 721-1219 · dental@rapidnet.com

We want to **WELCOME YOU TO OUR OFFICE …** The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form as completely as possible. The better we communicate, the better we can serve you.

Today's Date: _____ / _____ / _____

ABOUT YOU

First Name: _____ Middle Initial: _____ **Last**: _____ ☐ Male ☐ Female

Birth Date: ____ / ____ / ____ **Age:** _____ **SSN:** _____ ☐ Single ☐ Married ☐ Divorced

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-mail:_____ **For Apt. Reminders**: ☐ Call: H / C / W ☐ Text ☐ Email

Phone Number: (____)_____-_____ Employer: _____ Occupation: _____

Employers Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone: (_____) _____-_____

Responsible Party

Name: _____ Relationship to Patient: _____

SSN**:** _____ Birth Date: ____ / ____ / ____ Phone: (_____) _____-_____ ☐ Cell ☐ Home

Employer: _____ Work Phone: _____ ext: _____

Insurance / Self Pay

Self Pay: ☐ Cash ☐ Credit Card ☐ Care Credit **Driver's License #:** _____

Primary Dental Insurance Co.: _____**ID:**_____ **Group #:** _____

Phone: (_____) _____-_____ Address: _____ City: _____ State: _____ Zip:_____

Policy Holder's Name: _____ Relationship to Patient: _____ SSN: _____ DOB: ___ / ___ / ___

Secondary Dental Insurance Company: _____ **Group #:** _____

Phone: (_____) _____-_____ Address: _____ City: _____ State: _____ Zip:_____

Policy Holder's Name: _____ Relationship to Patient: _____ SSN: _____ DOB: ___ / ___ / ___

Policy Holder's Employer: _____ Address: _____

How did you hear about our office? ☐ Facebook ☐ Yellow Pages ☐ Website ☐ Friend ☐ Location/Sign

☐ Doctor _____ ☐ Patient _____ ☐ Other _____

*** **Whom may we thank for referring you?** _____

Dental History

Are you currently in pain? ☐ Yes ☐ No

Your dental concerns? _____

_____

Do you suffer from dental anxiety? ☐ Yes ☐ No

Are you happy with your smile? ☐ Yes ☐ No

What would you like to change? _____

Have you experienced jaw pain or discomfort? ☐Yes ☐No

Date of last dentist visit: __ / __ /____

Do you have any of the following concerns? ☐ Bleeding Gums ☐ Hot/Cold Sensitivity ☐ Sensitivity to Sweets ☐ Painful Biting

Use anything in addition to your brush & floss? ☐ Y ☐ N

If yes, what? _____

Do you require antibiotics before treatment? ☐Yes ☐No

Due to: ☐☐ Artificial Joints ☐☐ Infective Endocarditis

☐☐ History of infection in heart valve

Other: _____

_____

Medical History

Are you currently under the care of a Physician? ☐ Yes ☐ No

If yes, please explain: _____

Physician's Name_____

Address: _____

Phone #_____Date of last visit ___/___/___

For Women:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Unsure ☐ Yes ☐ No Week#_____

Are you Nursing? ☐ Yes ☐ No

Are you **allergic** to any of the following?

Yes No		Yes No	
☐ ☐	Antibiotics	☐ ☐	Jewelry/Metals
List all _____		☐ ☐	Latex
_____		☐ ☐	Sedatives
☐ ☐	Barbiturates	☐ ☐	Codeine
☐ ☐	Dental Anesthetics	☐ ☐	Lactose

Please list additional allergies _____

_____

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
☐☐	Antibiotics	☐☐	Blood Pressure Med	☐☐	Naproxen (Aleve)	☐☐	Thyroid Medicine
☐☐	Antihistamines	☐☐	Digitalis/Heart med	☐☐	Recreational Drugs	☐☐	Tranquilizers
☐ ☐	Antidepressants	☐☐	Ibuprofen	☐☐	Nitroglycerin	☐☐	Bisphosphonates, bone medications or shots
☐☐	Aspirin	☐☐	Other				

(please list all medications) _____

_____

_____

Do you or have you experienced the following?

Y N		Y N		Y N		Y N		Y N	
☐☐	Abnormal Bleeding	☐ ☐	Chemotherapy	☐☐	Heart Attack	☐☐	Migraines	☐☐	Sinus Problems
☐☐	Acid Reflux/GERD	☐ ☐	Colitis	☐☐	Heart Murmur	☐☐	Oral Herpes/Cold Sore	☐☐	Smoke/ Chew/ Vape
☐☐	Alcohol Abuse	☐☐	Congenital Heart Defect	☐☐	Heart Surgery	☐☐	Pacemaker	☐☐	Steroid Therapy
☐☐	Anemia	☐☐	Diabetes	☐☐	Hemophilia	☐☐	Psychiatric Problems	☐☐	Stroke
☐☐	Arthritis	☐☐	Difficulty Breathing	☐☐	Hepatitis _____	☐☐	Radiation Treatment	☐☐	Tonsillitis
☐☐	Asthma	☐☐	Drug Abuse	☐☐	HIV+/Aids	☐☐	Seasonal Allergies	☐☐	Tuberculosis (TB)
☐☐	Blood pressure high	☐☐	Epilepsy	☐☐	Joint replacement	☐☐	Seizures	☐☐	Ulcers
☐☐	Blood pressure low	☐ ☐	Fainting Spells	☐☐	Kidney Problem	☐☐	Sickle Cell Disease		
☐☐	Blood Transfusion	☐ ☐	Fever blisters	☐☐	Liver Disease	☐☐	Recent Surgeries (please list) _____		
☐☐	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. Additionally, we will discuss today's fees and any further treatment plan including fees as they are today. We require payment prior to the beginning of treatment.

*****PLEASE INITIAL WHERE NOTED WITH LINE:**

____ **Insurance is filed as a courtesy for the patient. Insurance co-payments are due at the time of service. Final responsibility for payments rests with the patient. The patient understands that it is their responsibility to report any changes in insurance coverage.**

____ PAYMENT OPTIONS THAT WE OFFER:
Cash/Check - Visa/MasterCard/Discover - Care Credit Financing (ask for application) - Pre-payment Option

____ A charge of $30 will be applied to accounts for any returned checks.

____ BROKEN APPOINTMENT POLICY:
I understand that a valuable amount of time is saved for all my appointments and if I fail to give proper notice of 24-48 hours prior to any appointment I will be paying a $50 broken appointment charge. If a second appointment is made and completed within reasonable time the charge will be reimbursed toward the treatment. Anderson Dental reserves the right to dismiss a patient from our practice for numerous appointments broken without 24-48 hour notice or appointments not confirmed.

____ APPOINTMENT VALUE
When scheduling treatment to be completed I understand that I will be paying a pre-treatment deposit with values as follow… (If treatment is not completed pre-treatment deposit will be forfeited.)
Under $500 of treatment a $50 deposit - Over $500 of treatment a $100 deposit - Over $1000 of treatment a $200 deposit
Any treatment over $2500 will be paid in full at least 2 days prior to treatment.

____ CONSENT FOR TREATMENT
I hereby authorize Anderson Dental and designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis. Upon such diagnosis, I authorize Anderson Dental and designated staff to perform all recommended treatment mutually agreed upon by me and to employ such professional assistance as required providing proper care. I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

____ The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims or benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that it is my responsibility to inform the dental office of any changes which affect the above information. I also have read and understand the broken appointment policy and my responsibilities. I have had all of my questions answered regarding these issues and agree to abide by these policies.

_____	_____
Patient Name (PRINTED)	Date

_____	_____	_____
Patient Signature	Parent/Responsible Party Signature	Relationship to Patient

ANDERSON DENTAL

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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 Message. 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? YES NO

If YES, please name the members allowed: _____

_____

_____

This consent was signed by: _____
(PLEASE PRINT NAME)

Signature: _____ Date:_____

Witness: _____ Date:_____

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.