

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired</p> <p>Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time</p> <p>Medicaid ID: _____ Pref. Dentist: _____</p> <p>Employer ID: _____ Pref. Pharmacy: _____</p> <p>Carrier ID: _____ Pref. Hyg: _____</p>	<p>Section 3</p> <p>INS. EFFECTIVE DATE: _____</p> <p>OK TO SPEAK TO: _____</p> <p>OK TO SPEAK TO: _____</p> <p>EMERGENCY CONTACT: _____</p> <p>EMERGENCY CONTACT: _____</p> <p>EMERGENCY CONTACT: _____</p> <p>EMERGENCY CONTACT: _____</p>
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Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

<p>Employer: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Benefits: _____</p>	<p>Ins. Company: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Deduct: _____</p>
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Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

<p>Employer: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Benefits: _____</p>	<p>Ins. Company: _____</p> <p>Address: _____</p> <p>Address 2: _____</p> <p>City, State, Zip: _____</p> <p>Rem. Deduct: _____</p>
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PATIENT NAME _____

DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
 Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____
Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Disease/Surgery, Excessive Bleeding, Chemotherapy, Night Sweats, Cold Sores, etc.

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Includes rows for Dr. signatures.

**Bangor Dental Associates
62 Corporate Drive
Bangor, ME 04401
(207) 947-7503**

INFORMED CONSENT TO BE SEEN

I understand that I may or may not require the following procedures over the course of my treatment at this office as recommended by my dentist:

- Any and all necessary x-rays
- Regular hygiene appointments, including fluoride and sealants if applicable.
- Periodontal treatment – Quadrant (or localized per tooth) scaling and root planing, 3 month periodontal maintenance appointments
- Restorations as explained by the doctor. This treatment may include fillings, crowns, bridges, extractions, partial dentures* and full dentures*.

All dental and anesthetic procedures have associated risks. These may include, but are not limited to:

- Drug reactions and side affects
- Bruising, swelling, sensitivity or pain
- Complications during treatment necessitating referral to a specialist
- Complications from extractions may include bruising, swelling, dry socket, nerve damage, infection and post operative bleeding and may require additional treatment.
- Damage to adjacent teeth or fillings
- Failure of the procedure requiring additional treatment

*** Partial and full dentures may require additional services with additional fees.**

Patient Signature _____

Date _____

Witness Signature _____

Date _____

YOUR RECOMMENDED TREATMENT PLAN AND ASSOCIATED FEES WILL BE MADE AVAILABLE TO YOU AT THE FRONT DESK AND ANY QUESTIONS YOU HAVE AT THIS TIME WILL ALSO BE ANSWERED.

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PERSONAL CONSENT FORM

YOUR DRIVERS LICENSE NUMBER: _____

EMAIL ADDRESS: _____
(USED FOR APPOINTMENT CONFIRMATIONS)

HOW DID YOU HEAR ABOUT US? _____

IN CASE OF EMERGENCY: CONTACT _____

RELATION: _____

PHONE#: H _____ W _____ C _____

IN ACCORDANCE WITH THE HIPAA REGULATIONS OF 1996, I HEREBY AUTHORIZE THE DOCTOR AND STAFF OF THIS PRACTICE TO RELEASE INFORMATION, SUCH AS FINANCIAL, APPOINTMENT AND PERSONAL INFORMATION, AS NEEDED, TO THE FOLLOWING PEOPLE/INSTITUTIONS (PLEASE CHECK ALL THAT ARE APPROPRIATE):

___ DENTAL CARRIER	___ MEDICAL OFFICE
___ SPOUSE	___ SECRETARY/OFFICE MANAGER
___ PARENTS	___ OTHER _____

ALL INFORMATION LISTED ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE MY DOCTOR TO RECEIVE AND RELEASE ANY INFORMATION AND/OR X-RAYS REGARDING MY TREATMENT.

PATIENT: _____ **DATE:** _____

PARENT / LEGAL GUARDIAN: _____ **DATE:** _____

**Bangor Dental Associates
62 Corporate Drive
Bangor, ME 04401
(207) 947-7503**

PAYMENT POLICY

PAYMENT IS DUE AT TIME OF SERVICE

We are committed to providing you with the best possible care. **Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures.**

If you have dental insurance, we will submit your claim for you, as a courtesy. We will estimate what we anticipate your insurance will cover and any amount owed by you (including any deductibles and/or co-pays) is due, in full, on the day of service.

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not included in your contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.
3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees. This may result in a balance due that is higher than initially expected. Should an outstanding balance result after your insurance company processes your claim, you will be mailed a statement. Payment is due in full by the due date printed on the statement.
4. If payment is not made by the due date printed on the statement, then your account will fall past due. Any accounts that fall more than 30 days past due are assessed a 1.75% (21% annually) finance charge. Accounts that have fallen more than 60 days past due are assessed a billing charge of \$10/month, in addition to the previously stated finance charge.
5. We reserve the right to forward any accounts that have fallen more than 90 days delinquent to a collection agency for further action.

We must emphasize that as health care providers, **our relationship is with you**, not your insurance company. While filing your insurance claims for our patients is a courtesy that was extended, **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED.**

- **FAILED APPOINTMENTS, OR APPOINTMENTS CANCELED WITHOUT 48-HOUR NOTICE MAY BE SUBJECT TO A BROKEN APPOINTMENT FEE**
- **AFTER INSURANCE PAYMENTS HAVE BEEN RECEIVED, IF THERE IS A CREDIT BALANCE, IT WILL BE HELD UNLESS YOU SPECIFY OTHERWISE**
- **PATIENT IS RESPONSIBLE FOR ANY BALANCE DUE & COSTS INCURRED TO COLLECT ON THE ACCOUNT**

I HEARBY AUTHORIZE MY INSURANCE COMPANY TO RELEASE PAYMENT FOR SERVICES DIRECTLY TO MY DOCTOR.

REGARDLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSIBILITY TO PAY MY BALANCE AND WILL PAY ANY BALANCE DUE.

Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

**Michele E. Spekhardt, DMD, P.A.
dba Bangor Dental Associates**

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
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Notice of Privacy Practices

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/13, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Jasmine Pike, Practice Director

Telephone: (207) 947-7503 Fax: (207) 945-4242

Address: 62 Corporate Drive, Bangor, ME 04401

E-mail: practicedirector@bangordentalassociates.com

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