CONFIDENTAL PATIENT INFORMATION

DATE: _____

One of the greatest compliments we could ever receive is where one of our patients refers a friend, co-worker, a loved one or family member to our practice. Please let us know who can thank you're your referral.

Please thank: _____ for referring me.

First Name: _____ Last Name: _____ M F

Preferred Name: _____ Preferred Pronoun: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: _____ HM WK CELL

Email Address: _____

Emergency Contact: _____ Relationship to PT: _____

Emergency Contact Phone No.: _____

INSURANCE INFORMATION

Are your covered under a Dental Insurance Policy? YES NO If yes, please complete the following:

Name of Insurance Company: _____

Policy Holder: _____ Relationship to PT: _____

Name of Employer Group: _____

Member ID, Subscriber ID or Social Security #: _____

Group #: _____ Date of Birth (if subscriber is not the PT): _____

AUTHORIZATION & RELEASE

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO FLAWLESS DENTAL, INSURACNE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENCERED. I AUTHORISE FLAWLESS DENTAL TO RELEASE MY INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMITTALS

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____

*Your social security number is required only if it the primary means of indemnifying your insurance policy.

MEDICAL HISTORY

Date: _____

Patient name: _____ Date of birth: _____

Please list any serious illnesses or injuries that you've been hospitalized for in the past five years:

_____

_____

If you have listed illnesses above, please provide the name and number of your Primary Care Physician

_____

Please list any medications (over the counter, prescription, or supplement) that you are taking and reason:

Medication (if more space is needed, please attach)	Reason medication or supplement is being used
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to the following?

☐ Amoxicillin ☐ Aspirin ☐ Erythromycin ☐ Metals/Jewelry ☐ Sulfa ☐ Codeine
☐ Latex ☐ Penicillin ☐ Novocain ☐ Epinephrine ☐ Tetracycline ☐ Other _____

If any items above are checked, please describe symptoms: _____

Have you ever had or currently have any of the following

☐ Anemia
☐ Alzheimer's or Memory Loss
☐ Artificial heart valves
☐ Cancer/ Chemotherapy
☐ Difficulty breathing
☐ Fainting
☐ Hearing Impaired
☐ Hemophilia (abnormal bleeding)
☐ Liver Disease
☐ Pacemaker
☐ Shingles
☐ Stroke
☐ Tumor Growth
☐ Angina
☐ Artificial hips or joints
☐ Cold Sores/Herpes
☐ Drug or Alcohol Abuse
☐ Gastrointestinal Disorder
☐ Heart attack
☐ Hepatitis A B C D
☐ Kidney problems
☐ Radiation treatments
☐ Smoking/Tobacco use
☐ Snoring / Sleep Apnea
☐ Ulcers
☐ Arthritis
☐ Asthma / Hay Fever
☐ Congenital Heart Defect
☐ Emphysema
☐ Glaucoma
☐ Heart murmur
☐ High/Low Blood Pressure
☐ Migraines
☐ Reflux
☐ Sinus Problems
☐ Thyroid Problems
☐ Venereal Disease
☐ Blood Transfusions
☐ Diabetes
☐ Epilepsy/Seizures
☐ Headaches (frequent, severe)
☐ Heart surgery
☐ HIV+ / AIDS
☐ Mitral Valve Prolapse
☐ Rheumatic/Scarlet Fever
☐ Stents in heart when: _____
☐ Tuberculosis
☐ Other _____

Have you ever taken osteoporosis treatment drugs? ☐ Yes ☐ No

Have you ever taken or are you currently on blood thinners? ☐ Yes, in past ☐ Never ☐ Currently on since _____

Any other medical issues we should be aware of? _____

FOR WOMEN: Are you currently taking birth control pills? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Premedication may be necessary if you have had any of the following:

° Prosthetic Cardiac Valve ° Previous bout of infective bacterial endocarditis ° Joint replacements
° Cardiac transplant patients who have had uvulitis ° Congenital heart disease excluding mitral valve prolapse

I hereby certify that the information I have given here today is correct to the best of my knowledge:

PATIENT SIGNATURE: _____ REVIEWED BY: _____
[DR/HYG INITIALS & DATE

PLEASE SIGN BOTH UPPER AND LOWER SECTIONS

ACKNOWLEDGEMENT OF RECEIPT:
NOTICE OF PRIVACY PRACTICES (HIPPA)*

I HAVE RECEIVED/REVIEWED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____
NAME OF PATIENT

_____
NAME OF PARENT OR GUARDIAN (If above is a minor)

_____ _____
PATIENT, PARENT OR GUARDIAN SIGNATURE TODAY'S DATE

* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT (Write "REFUSE" in the Signature Line)

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ACKNOWLEDGEMENT OF RECEIPT:
NOTICE OF FINANCIAL & ELECTRONIC COMMUNICATION POLICIES

I HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED TO ME IN THE FINANCIAL & ELECTRONIC COMMUNICATION POLICIES, AND THAT IT APPLIES TO MYSELF AND ANY MEMBER OF MY DESCRIBED FAMILY.

_____
NAME OF PATIENT

_____
NAME OF PARENT OR GUARDIAN (If above is a minor)

_____ _____
PATIENT, PARENT OR GUARDIAN SIGNATURE TODAY'S DATE

(CONTINUE TO NEXT PAGE FOR POLICIES)

NOTICE OF PRIVACY PRACTICES (HIPPA)

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice as long as it is in effect—as in, until we make appropriate revisions. We reserve the right to change our privacy practices at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices effective for all health information that we maintain, including health information we created or received before we made the changes. Upon changing our privacy practice, we will revise the terms of this notice, thus ensuring that the notice we abide by and distribute is up-to-date. You may request a copy of our notice at any time. For further information about our privacy practices or for additional copies of this notice, please feel free to contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information electronically or by mail to obtain payment from health plans and insurers for the care that we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Other Persons Involved in Care: We may use or disclose health information to notify a family member or a person responsible for your care of your location or of your condition. If you are present, then prior to use or disclosure of your health information, we will provide you the opportunity to object to such uses or disclosures. In the event of your incapacity or an emergency circumstance, we will use our professional judgement in disclosing only relevant health information to a person who is involved in your healthcare. We will also use our professional judgment and our experience with common practice to

make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, and other similar forms of health information.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as phone calls, voicemail messages, text, email, postcards, or letters).

Electronic Transfers: We may use or disclose your health information electronically to obtain payment, to refer to another health care provider, or if otherwise stated with your permission.

Abuse or Neglect: We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will do so only when we are compelled by our ethical judgement, when we are required by law, or with the patient's agreement.

Public Health and National Security: We may disclose your health information to officials completing an investigation related to public health or national security—including but not limited to the control of prevention of an epidemic or the understanding of side effects of a new drug treatment or medical device.

For Law Enforcement: As permitted or required by applicable law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including if you are the victim of a crime or in order to report a crime.

Marketing Health-Related Services: We will **not** use your health information for marketing communications without your written authorization.

Authorization to Use or Disclose Health Information: Other than is stated above or where applicable law requires us to do so, we will not use or disclose your health information without your written authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. You have the right to request restrictions on certain uses and disclosures on your health information—our office will make every effort to honor reasonable restriction preferences from our patients.

HIPPA COMPLIANCE OFFICER for Flawless Dental is Dr. Ruhi S, Khanna, MSc, DMD

(CONTINUE TO NEXT PAGE FOR POLICIES)

FINANCIAL POLICY

PAYMENT IS DUE AT THE TIME SERIVICES ARE RENDERED

In order to provide services which are financially manageable
to our patients, we offer the following options for payment.

Cash, Check or Credit Card, (Visa, MC, AMEX & Discover)
Care Credit*
Monthly Payment Plans for Orthodontic Treatment**
Primary Insurance Submittals

We will be happy to submit charges to your insurance carrier with advance notice of coverage. If we are unable to verify insurance coverage prior to your appointment we will gladly provide a paid receipt for direct reimbursement**. When submitting insurance, the estimated uncovered portion is due on the day of treatment**. (For those who have dual insurance, The estimated uncovered portion of your visit will be calculated based on information from your primary insurance carrier only. We will submit to your secondary insurance carrier as a courtesy. Monies received from your secondary carrier which result in a credit balance on your account will be returned to you by check or remain on the account for future treatment) Any balance(s) not covered by your insurance carrier(s) is your responsibility. All insurance balances over 60 days will be transferred to your account at which time we will notify you of your responsibility for payment.

YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE COVERAGE. WE WILL DO OUR BEST TO ACCURATELY ESTIMATE YOUR OUT OF POCKET EXPENSE, ALTHOUGH YOU ARE ULITMATLY RESPONSIBLE FOR ALL TREATMENT CHARGES.

The parent/guardian that accompanies a minor to a dental visit is the person responsible for payment.

*With approved credit from application. Use of Care Credit voids all fee schedule discounts relating to your treatment.
**With prior approval. A CREDIT CARD ON FILE WILL BE REQUIRED. ALL CHARGES WILL BE PLACED ON THIS CARD AT THE APPROPRIATE INTERVAL.

PLACING A CREDIT CARD ON FILE*

We will be happy to place a credit card on file in our secure cloud based system for ease of paying balances incourred during your treatment.

By placeing a card on file, you agree to have charges placed on the card for any/all balances for agreed upon services. An itemized receipt will be provided.

*If you are using a debit card or FSA, your card will be pre-authorized for the balance expected or $500.00 which ever is higher. Your issuing bank may or may not lock out funds to cover the pre-authorized amount. If so, this amount will not be available to you until the authorization is deleted or captured & processed.

MAKING CHANGES TO YOUR APPOINTMENT

Our schedule is designed with you in mind. Appointment times are specifically reserved for you with your provider. Your account will be assesed a fee of $100 if you cancel or reschedule less than 48 hours prior to your reserved time or if you miss your appointment in its entirety(confirmed or not)

YOU MUST CALL OR EMAIL to make changes as we do not monitor text messages outside of business hours.

ARRIVING LATE TO YOUR APPOINTMENT

The office reserves the right to reschedule your dental visit if you arrive

15 minutes or more past the start time of your appointment. We will do our best to accommodate you on your day of arrival, but it may not always be possible to do so.

IF YOUR PROVIDER IS UNEXPECTEDLY NOT AVAILABLE

Since your appontment is reserved for you with a specific provider, there may come a time when we find it necessary to alter or reschedule your dental visit. If we need to do so we will notify you as far in advance as possible. In the rare time we have to reschule your visit on the same day, we apologise in advance and we thank you for your understanding.

ELECTRONIC COMMUNICATION POLICY

This office uses email and sms (texting) as a means of correspondence to confirm appointments, to respond to patient requests and various other tasks**,** excluding marketing.

I agree the dental practice may communicate with me electronically at the email address and mobile number provided.

I am aware there is some risk a third party or parties might be able to read unencrypted emails and/or text messages

I am responsible for providing the dental practice with any updates to my email address or mobile number

I can opt out of emails at any time by requesting to do so with written notice to the practice.

I can opt out of text messages at any time by replying “Stop” or “Opt Out” to any text message received.