HANSER dental

CONFIDENTIAL

(PLEASE PRINT)

PATIENT INFORMATION

DATE_____

NAME_____ BIRTHDATE_____ HOME PHONE_____
FIRST MI LAST

CHECK APPROPRIATE BOX: CELL PHONE_____

☐MINOR ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPERATED

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY #_____ SPOUSE/PARENT NAME_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

CURRENT PATIENT AT OUR OFFICE? ☐YES ☐NO

IF PATIENT EMPLOYED:

EMPLOYER/RETIRED_____ DATE EMPLOYED_____

WORK PHONE_____ ADDRESS_____

INDIVIDUAL RESPONSIBLE FOR PAYMENT

NAME_____ RELATIONSHIP TO PATIENT_____ BIRTHDATE_____

HOME PHONE_____ ADDRESS_____

EMPLOYER_____ WORK PHONE_____

PAYMENT REQUESTED AT TIME OF SERVICE

PAYMENT PREFERENCE: CASH ☐ CREDIT/DEBIT ☐

DENTAL INSURANCE INFORMATION

INSURANCE CO_____ NAME OF INSURED_____

RELATIONSHIP TO PATIENT_____ BIRTHDATE_____ SOCIAL SECURITY #_____

EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

ADDITIONAL DENTAL INSURANCE INFORMATION

INSURANCE CO_____ NAME OF INSURED_____

RELATIONSHIP TO PATIENT_____ BIRTHDATE_____ SOCIAL SECURITY #_____

EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

X_____

SIGNATURE OF PATIENT/PARENT IF MINOR

PLEASE COMPLETE BACK SIDE

PATIENT NAME_____ DATE_____

MEDICAL HISTORY

PHYSICIAN_____ OFFICE PHONE_____ DATE OF LAST EXAM_____

DATE OF LAST PHYSICAL_____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. ARE YOU TAKING ANY MEDICATION(S), INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING?	☐	☐
4. DO YOU USE TOBACCO?	☐	☐
5. DO YOU USE CONTROLLED SUBSTANCES?	☐	☐
6. DO YOU USE ALCOHOL?	☐	☐
7. ARE YOU WEARING CONTACT LENSES?	☐	☐
8. HAVE YOU EVER TAKEN BIO-PHOSPHANATES?	☐	☐

_____

_____

_____

_____

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY:

_____

_____

_____

10. IF YOU NEED TO TAKE MEDICATION BEFORE ANY PROCEDURES, PLEASE LIST HERE:

_____

_____

11. WOMEN ONLY:

	YES	NO
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
B) ARE YOU NURSING?	☐	☐
C) ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

PLEASE INDICATE WHICH OF THE FOLLOWING APPLY TO YOU. CHECK ONLY IF THE ANSWER IS YES:

- ☐ AIDS OR HIV INFECTION
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ CANCER
- ☐ CARDIAC PACEMAKER
- ☐ CHEST PAINS
- ☐ DIABETES
- ☐ EASILY WINDED
- ☐ EMPHYSEMA
- ☐ EPILEPSY/CONVULSIONS
- ☐ FAINTING/SEIZURES
- ☐ FREQUENTLY TIRED
- ☐ GLAUCOMA
- ☐ HAY FEVER/ALLERGIES
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEART TROUBLE
- ☐ HEPATITIS/JAUNDICE
- ☐ HIGH BLOOD PRESSURE
- ☐ JOINT REPLACEMENT OR IMPLANT
- ☐ KIDNEY DISEASE
- ☐ LEUKEMIA
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ RADIATION THERAPY
- ☐ RECENT WEIGHT LOSS
- ☐ RESPIRATORY PROBLEMS
- ☐ RHEUMATIC FEVER
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ STOMACHE TROUBLE/ULCERS
- ☐ STROKE
- ☐ SWOLLEN ANKLES
- ☐ THYROID PROBLEM
- ☐ TUBERCULOSIS

COMMENTS _____

_____

DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLY TO YOU. CHECK ONLY IF THE ANSWER IS YES:

- ☐ GUMS BLEED WHILE BRUSHING OR FLOSSING
- ☐ TEETH SENSITIVE TO HOT/COLD LIQUIDS/FOODS
- ☐ TEETH SENSITIVE TO SWEET/SOUR LIQUIDS/FOODS
- ☐ FEEL PAIN TO ANY TEETH
- ☐ SORES OR LUMPS IN OR NEAR MOUTH
- ☐ HEAD, NECK OR JAW INJURIES
- ☐ JAW CLICKING
- ☐ PAIN IN JOINT/EAR/SIDE OF FACE
- ☐ DIFFUCULTY OPENING/CLOSING MOUTH
- ☐ FREQUENT HEADACHES
- ☐ CLENCH/GRIND YOUR TEETH
- ☐ BITE YOUR LIPS/CHEEKS FREQUENTLY
- ☐ DIFFICULT EXTRACTIONS IN PAST
- ☐ PROLONGED BLEEDING FOLLOWING EXTRACTIONS
- ☐ ORTHODONTIC WORK
- ☐ INSTRUCTION ON CORRECT METHOD OF BRUSHING TEETH
- ☐ INSTRUCTION ON CARE OF GUMS
- ☐ DIFFICULTY CHEWING

PREVIOUS DENTIST:_____ **REASON FOR TODAY'S VISIT:**_____

_____

_____

I have reviewed the information on this questionnaire, front and back, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurances. In the event that I fail to pay my bill, I agree to pay any additional charges related to the cost of collection included but not limited to collection fees, reasonable attorney fees and court costs.

X_____

SIGNATURE OF PATIENT

HANSER dental

Phone 618.667.2004
Fax 618.667.2526

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 09/18/2013, 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:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- 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: **Rhonda B. Hanser DMD**

Telephone: **618-667-2004** Fax: **618-667-2526**

Address: **334 Bargraves Blvd. Troy, IL 62294**

E-mail: **hanserdental@hotmail.com**

Rhonda B. Hanser, D.M.D.
334 Bargraves Blvd.
Troy, IL 62294
(618) 667-2004 Office
(618) 667-2526 Fax

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the the individual's home.

Patient Name:_____ **Patient Birth Date:**_____

I wish to be contacted in the following manner (check all that apply):

_____ Home telephone _____

_____ Cell_____
_____ O.K. to leave messge with detailed information
_____ Leave message with call-back number only

_____ Work Telephone
_____ O.K. to leave message with detailed information
_____ Leave message with call-back number only

_____ Written Communication

_____ O.K. to mail to my home address
_____ O.K. to mail to my work/office address
_____ O.K. to fax to number indicated _____

_____ Email address _____
Unencrypted email is not a secure form of communication. I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

I allow you to give my clinical information to or answer questions from (check all that apply):

_____ Spouse: name_____
_____ Parent: name_____
_____ Child: name_____
_____ Other: (specify) _____
_____ None

_____ _____
Patient (or legally authorized individual) signature Date

_____ In front of _____
Relationship to patient (parent, legal guardian), etc Practice Representative

Hanser Dental
{NAME OF PRACTICE}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

_____
Please 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)

_____

_____

_____