Patient Registration Form

Today's Date: _____ DOB: _____ Patient Social Security #_____

Patients Name_____

(Last) (First) (Middle Initial) (Preferred)

Address_____

City_____State_____Zip_____

Drivers License # _____ Male Female Single Married Child Other _____

Home Phone #_____Work Phone #_____Other #_____

Email address_____

Best form of communication: I prefer ☐email ☐text ☐phone call

Employer_____Occupation_____

Employer Address_____

In Case of Emergency Contact:

Name_____Relationship_____

Address_____ Contact #_____

How did you hear about our office? _____

Account Information:

Individual Responsible for this account _____

(Last) (First)

Relationship to patient _____ DOB: _____Social Security #_____

Address_____

City_____State_____Zip_____

Employer_____ Group #_____

Insurance Carrier _____Customer Service #_____

Claims Mailing Address _____

City_____State_____Zip_____

Any additional Insurance coverage:

Relationship to patient _____DOB: _____Social Security #_____

Employer _____ Group #_____

Insurance Carrier_____ Customer Service #_____

Claims Mailing Address_____

City_____State_____Zip_____

Authorization to pay benefits to dentist

I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

Terms and conditions

Undersigned hereby authorizes Sunflower Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Sunflower Dental to make a thorough diagnosis of patient's dental needs. I also authorize Sunflower Dental to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Danielle Franklin choose and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand responsibility of payment for dentist services provided in the office for myself or my dependents is mine, due and payable at the time of services rendered unless financial arrangements have been made. I further understand that in the event of default I promise to pay legal interest on the indebtedness.

_____ _____

Patient/Guardian Signature Date

HEALTH HISTORY

Patient Name_____ DOB: _____

Physicians' Name _____Phone #_____

Physicians Address _____City_____Zip_____

1. Are you in good health? _____ YES NO

2. Has there been any change in your general health within the past year? _____ YES NO

3. Date of last physical examination? _____

4. Are you now under the care of a physician?_____ YES NO

   If so what condition? _____

5. Have you ever had any serious illness, operation, or hospitalization? _____ YES NO

6. Are you taking any drugs or medication? _____ YES NO

7. List type amount and frequency if so_____

8. Are you using any recreational drugs? _____ YES NO

9. Are you taking any over the counter drugs?_____ YES NO

10. Are you sensitive or allergic to any medication? _____ YES NO

    Penicillin Sulfa Codeine/other Narcotic Aspirin Barbiturates Iodine other _____

11. Do you have or have you had any of the following: (Please check known conditions)

Aids or HIV	Rheumatic Fever	Arthritis	Diabetes
Anemia	Blood Diseases_____	Head Injuries	Epilepsy
Artificial Joints	Sinus Trouble	Stomach Ulcers	Stroke
Heart Ailments	Sickle Cell Anemia	Venereal Disease	Heart Murmur
High Blood Pressure	Kidney Disease	Mental Disorders	Respiratory Disease
Radiation treatment	Asthma/Hay Fever	Tumors/Growths	Tuberculosis
Nervous Disorders	Fainting Spells/ Seizures	Allergies_____	Glaucoma
Excessive Bleeding	Hepatitis, Jaundice or liver disease	Other_____	None of the above

If you checked yes to any of the above conditions, please give a brief explanation:

_____

12. Do you use tobacco now or in the past?_____ YES NO

13. Do you wear a cardiac pacemaker?_____ YES NO

14. Have you had Heart surgery? _____ YES NO

15. Do you have any disease or condition or problem not list above that you think I should know about? YES NO

    If yes, what is it? _____

16. If you are Women, are you pregnant or nursing? If so, how many months? _____

DENTAL HISTORY

17. Previous Dentist_____City_____State_____Zip_____

18. Was your pattern of visits ☐regular ☐infrequent ☐sporadic Date of Last Dental Visit_____

19. Have you been having any specific problems? YES NO

Explain_____

20. Have you ever been pre-medicated with antibiotics (i.e. Penicillin, etc.) before dental treatment? _____ YES NO

21. Does dental treatment make you nervous? _____ YES NO

22. Do you have or have not had any of the following: (Please check known conditions)

Bad Breath	Loosening of teeth	Bleeding gums	Cold sores	Clench your teeth
Sensitive Teeth at Night Day	Sweet Temperature	Grind your teeth at Night Day		Hurt Lock Jaw Pop

23. Have you ever had any serious trouble associated with any previous dental treatment? _____ YES NO

24. Have you ever had any of the following: Injury Oral Surgery Orthodontics Periodontics

Is there anything about the appearance of your teeth you have ever wanted to change?

Explain_____

Patient/Guardian Signature Date Doctor Signature

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how you health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, 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 teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you 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, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified 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 be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in witting and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your 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 request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonably requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your 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 to provide you with notice of our legal duties and privacy practice with respect to protect health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, retaliate against you for filling a complaint.

- For Information about HIPAA or to file a Complaint: The U.S. Department of Health & Human Services Office of Civil Rights – 200 Independence Avenue, S.W. Washington, D.C. 20201 – (202)619-0257 – Toll Free : 1-877-696-6775

Patient Consent Form

You May Refuse to Sign This Acknowledgement

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 have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 above 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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Patient Name **Date**

_____

Signature

OFFICE POLICIES

It is your responsibility to keep all appointments. If you cannot keep your scheduled appointment time, in consideration of other patients in need of treatment, we kindly ask that you give the office a **24 hour advance notice**, so that we may offer your reserved time to another patient who is in need of our care. If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule.

Payments are due at the time of visit. This includes all Co-pay's, co-insurance, and deductible amounts, for your convenience we accept Cash, Check, Visa, and MasterCard.

Return checks "any bad check can and will be turned over to the justice of the peace if the account is not reconciled within 20 days." You will also be responsible for a returned check fee in the amount of $25.

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

Professional courtesies are between dentists. I agree not to requests records until I have a new dentist.

INSURANCE POLICIES

We participate in several dental plans. It is *your responsibility* to verify that we do participate on your plan. It is also your responsibility to know the terms, limitations, and benefits of your plan.

If we file insurance on your behalf, we need a copy of your current insurance card; you are required by your insurance company to pay all co- pay's, coinsurance, and deductibles which are due and payable at the time of service.

Verification of your insurance does not guarantee payment. Payment is subject to review by your insurance company. Payment is determined upon the actual receipt of the claims by the insurance company. If your insurance denies payment for services, you will be billed and it is your responsibility to pay for the service within 45 days of the date of treatment. It is your responsibility to contact your insurance company to dispute any denial, or nonpayment issues.

We will be happy to assist you in preparing forms or printing receipts for you to file with your insurance company.

I, the insured/dependant, have read the above and understand the policies regarding office and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services provided.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**

FINANCIAL AGREEMENT

I, _____, understand that any service performed for my dependant or me by Dr. Danielle Franklin or her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Danielle Franklin's office's responsibility to collect from my insurance company.

Dr. Danielle Franklin's office will file an initial insurance claim on my behalf as a service to me at no additional cost. If my insurance carrier has not responded within 45 days of the date of the service the entire fee for the service is due and payable by me. I understand any remaining balance regardless of the amount of the insurance payment is my responsibility.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**