Patient Registration Form

Today's Date:	DOB:	Patient Soc	ial Security #	
Patients Name				
	(Last)	(First)	(Middle Initial)	(Preferred)
Address				
City			State	Zip
Drivers License #	Male	Female Single	Married Child Other	
Home Phone #	Work Ph	one #	Other #_	
Email address				
	ation: I prefer 🗌 email 🔲 text			
Employer		Occupation		
Employer Address				
In Case of Emergency (
Name		Relationship		
Address			Contact #	
How did you hear abou	it our office?			
Account Information:				
Individual Responsible f	or this account			
		(Last)		(First)
Relationship to patient		DOB	Social Security #	

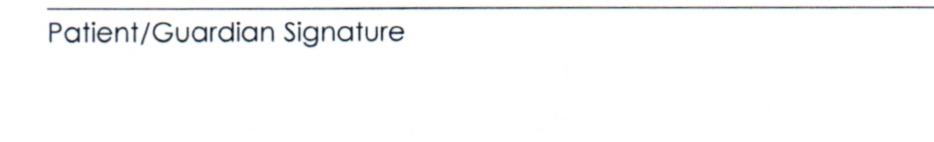
Address			
City		Zip	
Employer			
Insurance Carrier			
Claims Mailing Address			
City		Zip	
Any additional Insurance coverage:			
Relationship to patient	DOB:	_Social Security #	
Employer		Group #	
Insurance Carrier	Custo	ner Service #	
Claims Mailing Address			
City		Zip	

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.





HEALTH HISTORY

Pa	ient Name DOB	:		
Ph	rsicians' NamePho	ne #		
Ph	vsicians AddressCit	yZip		
1.	Are you in good health?		YES	NO
2.	Has there been any change in your general health within the past ye	ar?	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

- Are you taking any over the counter drugs?
- Are you sensitive or allergic to any medication? ______

YES NO

Penicillin Sulfa Codeine/other Narcotic Aspirin Barbiturates Iodine other _____

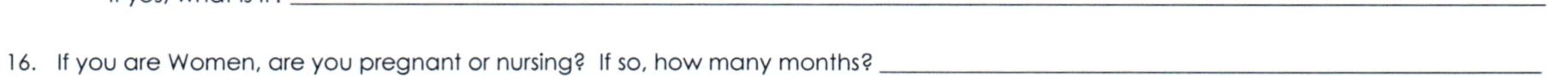
11. Do you have or have you had any of the following: (Please check known conditions)

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 Excessive Bleeding	Fainting Spells/ Seizures Hepatitis, Jaundice or liver disease	Allergies Other	Glaucoma 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? _____



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	c problems?			YES NO	0
	Explain					
20.	Have you ever been pre-medicate	d with antibiotics (i.e. Penic	cillin, etc.) before dental treatme	nt?	YES NO	0
21.	Does dental treatment make you n	ervous?			YES NO	С
22.	Do you have or have not had any	of the following: (Please ch	eck known conditions)			
	Bad Breath Lo	osening of teeth	Bleeding gums	Cold sores	Clench your teet	th
	Sensitive Teeth at Night Day Swe	et Temperature	Grind your teeth at Night	Day	Hurt Lock Jaw Po	p

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. ٠ 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 ٠ 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. ٠
- The right to amend your protected health information ۲
- The right to obtain a paper copy of this notice from us upon request. ٠

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 ٠ treatment directly and indirectly.
- Obtain payment from third-party payers. ۲
- Conduct normal healthcare operations such as quality assessments and physician certifications. ٠

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.



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

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.

DATE

DATE

PATIENT/GUARDIAN SIGNATURE