Valmont Dental

Rodger Miller, DDS

PATIENT INFORMATION

First name: ____________________ MI: _____ Last name __________________ Nickname: ______________

Address: _____________________________ City: _________________ ST: ________ Zip: _______________

Home Phone: _________________ Cell Phone: _________________ Email Address: _____________________

Date of Birth: ______________ Social Security # _________________ Driver's License # _________________

Are you a new patient? __________________ Referred by: ____

Employer: _____________________________ Occupation: ____

Work Address: ___________________________ City: ________________ St: __________ Zip: _____________

Work Phone: _________________________ Extension: ____________

PARTY RESPONSIBLE FOR ACCOUNT (if not yourself)

Spouse/Other: ____

Address: (If different) ____

Date of Birth: ________________ Home/cell phone: ___________________ Email: ______________________

Employer: _____________________________ Occupation: ____

Work Address: _________________________ City: ________________ ST: ___________ Zip: _____________

Work Phone: ________________________ Extension: _______________

EMERGENCY CONTACT

Name: _______________________________________ Relationship: ________________________________

Address: _____________________________City: ________________ ST: _____________ Zip: ___________

Home phone: _______________________ Cell phone: ________________ Work phone: _________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co: ___________________________________ Group # ____________________________

Subscriber Name: ____________________ Date of Birth: ____________ Member I.D. # __________________

Address of Insurance: ______________________________________ Phone # _________________________

Secondary Insurance Co: _________________________________ Group # ___________________________

Subscriber Name: ______________________ Date of Birth: ____________ Member I.D. # ________________

Address of Insurance ______________________________________ Phone # _________________________

Health Information / Medical History Form

HAVE YOU EVER HAD:

- ❑ Rheumatic Fever
- ❑ Damaged Heart Valves
- ❑ Artificial Heart Valves
- ❑ Vascular Graft or Stent
- ❑ Heart Murmur
- ❑ High / Low Blood Pressure
- ❑ Chest Pain / Angina
- ❑ Heart Attack
- ❑ Irregular Heartbeat
- ❑ Cardiac Pacemaker
- ❑ Heart Surgery
  - When? ______________
- ❑ Congenital Heart Defect
- ❑ Stroke
- ❑ Bronchitis
- ❑ Emphysema
  - Required Oxygen at home? Y / N
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Jaundice
- ❑ Blood Transfusion
- ❑ Bleeding Tendency
- ❑ Fainting Spells
- ❑ Convulsions / Epilepsy
- ❑ Hyperthyroidism / Hypothyroidism
- ❑ Diabetes
- ❑ Low Blood Sugar
- ❑ Kidney Disease
- ❑ Dialysis
  - Schedule ______________
- ❑ Immunosuppression
- ❑ Organ Transplant
- ❑ HIV
- ❑ A Tumor or Growth
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Psychiatric Treatment
- ❑ Sexually Transmitted Disease
- ❑ A History of Drug Abuse

Signature:

____

ARE YOU NOW OR HAVE YOU EVER TAKEN:

- ❑ Actonel
- ❑ Aredia
- ❑ Boniva
- ❑ Didronel
- ❑ Fosamax
- ❑ Skelid
- ❑ Reclast
- ❑ Zometa

ARE YOU CURRENTLY TAKING:

- ❑ Aspirin
- ❑ Plavix
- ❑ Pradaxa
- ❑ Lovenox
- ❑ Coumadin / Warfarin
- ❑ Gingko Biloba

PLEASE LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING:

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ARE YOU ALLERGIC TO, OR HAD A REACTION TO:

- ❑ Aspirin
- ❑ Codeine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin / Amoxicillin
- ❑ Sulfa Drugs
- ❑ Other ________________

DO YOU USE:

- ❑ Snoring Appliance
- ❑ CPAP Machine

DO YOU SMOKE OR USE SMOKELESS TOBACCO? Y/N

Date:

____

HAVE YOU HAD A JOINT REPLACEMENT, METAL SCREWS OR PLATES, OR IMPLANT OF ANY KIND? Y/N

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WOMEN, ARE YOU:

- ❑ Pregnant
  - Delivery date ________
- ❑ Nursing
- ❑ Taking Birth Control Pills

NOTE: It is possible that antibiotics may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

DO YOU HAVE ANY SERIOUS ILLNESS OR CONDITION NOT LISTED?

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PHYSICIANS NAME, ADDRESS, AND PHONE:

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Financial and Cancellation Policy for Valmont Dental

Please take a moment to familiarize yourself with our financial policy. We believe good communication concerning our policy regarding insurance and financial issues will help you understand our expectations. If at any time you have any questions about fees, treatment or payment, please feel free to talk to us about them.

Patients With No Dental Insurance

Payment is due in full at the time of service. We accept cash, checks, DISCOVER, VISA, AMERICAN EXPRESS & MASTERCARD. We also offer CARE CREDIT financing. Please see our front desk staff for more information.

Patients With Dental Insurance

The insurance plan which we are contracted with is Delta Premier. Your insurance coverage is evaluated to the best of our ability prior to your visit. We will provide you with an ESTIMATE based on the information provided to us by your insurance company. Your estimated portion may be due in full at the time of your treatment. However, if your insurance does not pay the full remaining balance, you will be billed for any additional balance. If your insurance pays more than the balance remaining, we will issue a refund check to you. Refund checks are issued once monthly.

If your insurance is a managed care plan, you are required to see a provider within that network. IT IS YOUR RESPONSIBILITY TO KNOW IF YOU HAVE THIS TYPE OF INSURANCE PLAN. This information is unavailable to us.

If you have dual insurance, please understand the entire balance may not be covered by both insurance plans and you will receive a bill for any remaining balance. Some insurance plans have a NON-DUPLICATION clause, which means the secondary insurance will not make a payment if the primary insurance does.

Cancellations

If you have to cancel or reschedule your appointment, please give us notice within two business days of your scheduled appointment. Please note that we reserve the right to charge a fee for the broken appointment otherwise.

I have read and accept the terms of this financial and cancellation policy. I understand I am responsible for payment and will responsible for any legal fees incurred in the collection of my account. I authorize payment of benefits by my insurance company to be made to Valmont Dental.

Signature: ___________________________________

Print Name: __________________________________

Date: _______________________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICES DESCRIBED HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal law 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 Notices while it is in effect. This Notice takes effect (04/01/2014), and will remain in effect until we replace it.

We reserve the right to charge our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we the changes. Before we make a significant change in our privacy practice, we will change this Notice and make the new Notice available 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 Notices, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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

Payment: We may use or disclose your health information to obtain payment for services 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 or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death.

If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others:

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 of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. 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 copies, we will charge you a minimal fee for the copies, to cover staff time, copying fees for your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
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.
Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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 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 U.S. Department of Health and Human Services

Acknowledgement of Receipt of

Notice of Privacy Practices

I, ____, have received a copy of Valmont Dental's Notice of Privacy Practices

____

Name (print)

________________________ ____________________

Signature Date

OFFICE USE ONLY

On _________________, an *Acknowledgement of Receipt of Notice of Privacy Practices* form was delivered. The form was not signed due to:

- o Communication barriers which prevent acknowledgement
- o An emergency which prevents acknowledgement
- o A refusal sign
- o Other ____

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than the terms specifically described below.)

TO: ____________________ PATIENT NAME: ___________________

FAX: __________________ DOB: _________ SSN: ________________

RELEASE TO: ____

I request and authorized the above-named doctor or healthcare provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition (s):

INFORMATION REQUESTED:

____ Copy of complete dental chart
____ Copy of dental x-rays
____ All treatment rendered
____ Others (e.g. models – described)

DATES COVERED:

____

AUTHORIZATION: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may receive this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____________ (date supplied by patient); or ____________ if revoked in writing by patient; or ___________ 180 days from the date hereof; or ___________ under the following conditions:*

____.

OTHER CONDITIONS: A Copy of this Authorization or my signature therein ______ may, or ______ may not be used with the same effectiveness as an original.

____
Patient Name (Print)

____________________________ ____________________________
Person authorized to sign for patient — State how authorized

____________________________ ____________________________
Signature — Date