TIME 09:45 AM DATE 5/4/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 9:48 AM | Morrell Dental | Date 5/4/2016

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

HIPPA Consent Form

This notice describes how medical information about you may be used and disclosed and now you can get access to this information. Please review this notice, sign and return to this office.

As of April 14, 2003, Morrell Dental is required by law to take reasonable steps to ensure the privacy of your personally identifiable health or medical information and to inform you about:

- Our uses and disclosures of protected health information(PHI)
- Your privacy rights with respect to your PHI and this office
- Our responsibilities with respect to your PHI
- The person or office to contact for further information about our privacy practices
- Your health right to file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services.

A. **Notice of PHI Uses and Disclosures**

Upon your request, our office is required to give you access to certain PHI in order to inspect or copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate our compliance with privacy regulations. Our office and our business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. Business Associated means a person who on behalf of our offices performs a function or activity involving the use or disclosure PHI. Treatment is the provision by for which we use or release PHI. It also includes but is not limited to consultations between referrals to one or more of your providers. Payment includes but is not limited to actions to make coverage determinations and payment including billing, claims, and reviews for medical necessity.

The following is a disclosure that requires you to be given an opportunity to agree or disagree prior to use, release or disclosure.

- Information given directly to family members, relatives or close personal friends. Release of this information will only be allowed after you have agreed to the disclosure or have been given the opportunity to object to such release.

Use and disclosure is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities.
- When authorized by law to report information regarding abuse, neglect or domestic violence.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- When subject to a request from a coroner for identification purposes.
- When authorized by and to the extent necessary to comply with workers compensation or other similar programs established by law.

B. Right to Request Restriction on PHI Uses and Disclosures

You may request that this office restrict uses and disclosers of your PHI to carry out treatment, payment and health care operations. However, our office is not required to agree to your request. This office will accommodate reasonable requests to receive communication of PHI by alternative means or alterative locations. You will be required to complete a form to request restrictions on uses and disclosures of your PHI, such request should be made to:

HIPPA Compliance Officer for Morrell Dental
403 S. 11th St. Suite 200
Boise, Idaho 83702
(208)342-3440

C. Right to Amend PHI

You have the right to request that our office amend your PHI or a record about you in our files. Our Office has 60 days to act on the request. If this request is denied in whole or part this office must provide you with a written denial. Requests to amend should also be sent to the HIPPA Compliance Officer.

D. Right to Receive Notice of PHI Disclosures

At your request, this office will provide you with an accounting of disclosures by your office of your PHI for a requested period of time not prior to six years of the request. This office has the right to charge a reasonable amount for more than one request and will comply with any request in 60 days or less. A 30day extension will be provided if we are unable to comply within the initial time frame.

E. Right to Receive a Paper Copy of This Notice

To obtain a paper copy of this notice contact the HIPPA Compliance Officer.

F. Note about Personal Representatives

You may exercise your rights through a personal representative provided this person is able to establish and demonstrate power of attorney notarized by a public notary or via a court order or if you are the parent of a minor. This office retains the right to deny access to PHI to any persons other than yourself to provide protection of your PHI.

G. Duties of this Office

This office is required by law to maintain the privacy of your PHI and provide notice of its legal duties and privacy practices. This notice is effective April 14, 2003. This office reserves the right to amend or change its privacy policy and practices provided such changes are communicate to past and present participants.

E. Minimum Necessary Standard

When using or disclosing PHI our office will make reasonable efforts not to disclose more than the minimum amount of PHI needed to accomplish the purposes of use. However minimum necessary standards will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment.
- Uses or disclosures made to you.
- Disclosures that are required by law.
- Uses or disclosures that is required for this office to comply with legal regulations.

This notice does not apply to information that has been de-identified. De-identified means that the information does not identify you and where there is not reasonable belief that this information could be used against you.

If you feel that your privacy rights have been violated you may complain to the HIPPA Compliance Officer at this office or you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

Secretary DHHS
Hubert H. Humphrey Building
200 Independence Ave. S.W.
Washington, D.C. 20201

PHI use and disclosure by our office is regulated by the federal law know as HIPPA (Health Insurance Portability Access and Accountability). You may find these rules at 45 Code of the Federal Regulations Part 160 & 164. This notice summarizes these regulations.

I have reviewed the privacy notice of this office.

Printed Name:

Signature:

Date:

MORRELL DENTAL

PAYMENT & INSURANCE POLICIES

PAYMENT POLICY

a. Patients without insurance must take care of charges in full on the day of the visit.

b. Patients with insurance must take care of all copays and estimated portions in full on the day of the visit.

c. Patients will not be scheduled for further treatment until all balances from current work are paid in full.

d. At 45 days all patients become fully responsible for all balances owed, wether insurance has paid or not. If insurance pays after that time, you will be reimbursed for any overpayment.

e. At 60 days all outstanding balances will incur a finance charge of 1.3% per month (16% per year) with a $5.00 minimum charge.

f. At 90 days, unpaid or delinquent balances will be referred for collection proceedings.

g. Regardless of who has financial custody of children in the event of divorce, the parent who brings the child to the office is responsible for payments of that account at the time of visit.

h. We can offer you an interest free loan through an outside credit agency if you need. Ask us for details prior to scheduling your dental work.

INSURANCE POLICY:

a. The treatment we recommend may or may not agree with the provisions of your benefit package. You should always have the right to accept or deny any treatment we might recommend.

b. ***We do not represent, guarantee or promise that your insurance will pay for any procedure we provide.***

c. ***We cannot take responsibility for benefit limits, excluded services, restrictions, policy limitations, copays and yearly maximums that may define your plan.***

d. ***We will do our best to estimate your insurance benefits and limits, based on industry norms. We assume no financial responsibility for the accuracy of those estimates.***

e. If you have double insurance you must take care of all copays and estimated portions on the day of the visit, as if you had single insurance coverage. We will then file insurance forms with your secondary insurer and you will be reimbursed at the time they pay on the claim.

f. In any case, you are ultimately responsible for any and all charges, in full, for any treatment we provide regardless of insurance.

g. Should insurance pay more than expected, any amounts you overpaid will be refunded to you.

NAME_____ **SIGNATURE**_____ **DATE**_____

(PRINT NAME)

MORRELL DENTAL

APPOINTMENT POLICY

a. We make every effort to run on schedule. If unforeseen scheduling issues arise, we will contact you to discuss options in order to respect your time.

b. Please schedule appointment times you are certain will work for you, and give us at least 24 hours (preferably 48 hrs) notice if you need to make a change.

c. A $35 no show- fee will be incurred without the courtesy of proper notice.

d. After 2 no-shows, patients will not be scheduled without pre-payment of all appointment charges.

NAME_____ **SIGNATURE**_____ **DATE**_____

(PRINT NAME)