JACOB O. LAYER, DMD

1485 E. McAndrews Rd • Medford OR 97504

PATIENT INFORMATION

Birthday:_____ SSN: _____-____-_____ Male ☐ Female ☐ Date:_____

Patient's name:_____
Last First Middle Nickname

Mailing Address: _____
Street City State Zip

Street Address:_____
Street City State Zip

Phone:_____ _____
Home Work Cell Email

Whom may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Responsible party name:_____
Last First Middle Nickname

Mailing Address:_____
Street City State Zip

How long at this address?_____ Phone:_____
Home Work Cell

Previous Address if less than 3 years:_____

Birthday:_____ SSN: _____-____-_____ Relationship to Patient:_____

Employer:_____ Occupation:_____ Years Employed:_____

Spouse's Name:_____ Birthday:_____ SSN: _____-____-_____

INSURANCE INFORMATION

Insured's Name:_____ Birthday:_____ SSN: _____-____-_____

Insurance Company:_____ Group #:_____ Subscriber ID #:_____

Mailing Address:_____
Street City State Zip

Dual ins? Yes☐ No☐ Insured's Name:_____ Birthday:_____ SSN: _____-____-_____

Secondary Ins Co:_____ Group #:_____ Subscriber ID #:_____

Mailing Address:_____
Street City State Zip

EMERGENCY CONTACT INFORMATION

Nearest relative not living with you:_____ Phone:_____

Address:_____
Street City State Zip

Phone: (541) 734-0970 • Fax: (541) 734-2081
drjakedmd@yahoo.com • www.layerdental.com

Medical History

Medical Physician:_____
Name Address Phone Fax

Date of last visit:_____ Have you ever had a serious illnesses or operation? □ Y □ N
If yes, please describe:_____

Please check if you have ever had any of the following:

☐ AIDS	☐ Epilepsy	☐ Kidney problems	☐ Spina Bifida
☐ Anaphylaxis	☐ Fainting	☐ Liver problems	☐ Stroke:
☐ Anemia	☐ Food allergies	☐ Nervous problems	☐ Surgical implant
☐ Arthritis/Rheumatism	☐ Glaucoma	☐ Pacemaker	☐ Swelling feet/ankles
☐ Artificial heart valve	☐ Headaches	☐ Psychiatric care	☐ Thyroid problems
☐ Artificial joints:_____	☐ Heart murmur	☐ Radiation treatment	☐ Tonsillitis
☐ Asthma	☐ Heart problems	☐ Rapid weight change	☐ Tobacco habit:
☐ Chemical dependency	☐ Hemophilia	☐ Respiratory problems	☐ Tuberculosis
☐ Chemotherapy	☐ Hepatitis A B C	☐ Rheumatic fever	☐ Ulcer
☐ Circulatory problems	☐ Herpes	☐ Scarlet Fever	☐ Venereal disease
☐ Cortisone treatment	☐ High blood pressure	☐ Shortness of breath	☐ Cancer
☐ Cough, persistent	☐ HIV positive	☐ Skin rash	
☐ Diabetes type I or II	☐ Jaw pain	☐ Sinus problems	

Have you ever had a blood transfusion? □ Y □ N If yes, give approximate date:_____

Women: Are you pregnant? □ Y □ N Nursing? □ Y □ N Taking birth control medication? □ Y □ N

Are you allergic to (circle all that apply) : Latex Penicillin Sulfa Codeine Metals Other:_____

Medications you are currently taking: _____

_____

_____

Authorization

I have reviewed the information on this questionnaire 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. If there is any change in my medical status, I will inform the dentist. I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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 paid by insurance or not.

Patient/Parent/Guardian	Signature	Date

Dental History

What would you like to accomplish today? _____

What prompted you to seek dental care at this time?_____

Have you been asked to take an antibiotic before dental treatment? ☐ Yes ☐ No

Please check if you have ever had problems with any of the following:

☐ Sensitivity to Cold/Hot	☐ Grind/Clench Teeth	☐ Dark Teeth	☐ Mouth Sores/Growths
☐ Sensitivity to Sweets	☐ Clicking or Popping Jaw	☐ Food Sticks Betw Teeth	☐ Bad Breath/Taste
☐ Jaw/Ear Pain	☐ Worn/Chipped Teeth	☐ Dry Mouth	☐ Bleeding Gums
☐ Sensitivity when biting	☐ Loose Teeth/Broken	☐ Periodontal Treatment	

Homecare Evaluation

Is it difficult for you to brush or floss any areas of your mouth? ☐ Yes ☐ No
Do you snack between meals on sweets, gum, or soda pop? ☐ Yes ☐ No

Smile Evaluation

How do you feel about the appearance of your teeth and smile? _____
Is there anything that dissatisfies you about your teeth or smile? _____
Are your teeth white enough? ☐ Yes ☐ No
Are your teeth straight enough? ☐ Yes ☐ No

Other History

Has cost prevented you from enhancing your smile in the past? ☐ Yes ☐ No
Do you feel like keeping your teeth healthy has been a losing battle? ☐ Yes ☐ No
Has anxiety, fear or discomfort kept you from regular dental visits in the past? ☐ Yes ☐ No
Have you ever had a reaction to a dental product or procedure? ☐ Yes ☐ No

If yes, please describe:_____

Previous Dentist:_____
Name City/State Phone

Date of Last visit:_____ Date of Last X-rays:_____
Month/Year Month/Year

FINANCIAL POLICY

MISSION STATEMENT:
ñ*We educate and empower individuals to achieve optimal dental health. We accomplish this through genuine relationships, excellent communication, and professional dental care.*ò

Payment is expected at the time of service. If you have a dental insurance plan your co-payment and deductible are due at the time of service. As a service, we will bill your insurance company for you.

ACCEPTED FORMS OF PAYMENT:

1. Cash, check, debit or credit cards (Visa, MasterCard, and Discover).
2. Most dental insurance plans.
3. Third party financing that is approved by the practice of Jacob O. Layer, DMD.

DENTAL INSURANCE:

- **PRIMARY INSURANCE**: We require that all insurance co-pays and estimated patient balance, minus estimated insurance assistance, be paid at the time of service. As a service, we will bill your insurance for services rendered. To do so we must receive an updated copy of your insurance card at your first appointment. If necessary, we will submit a pre-treatment ñestimate of benefitsò request to your insurance company before we schedule your treatment. This allows us to obtain an ***estimate*** of your dental benefits and the ***estimated*** amount your dental plan expects you to be responsible for. **While we help you to maximize your allowable insurance benefit, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us.** Any balance not paid by the insurance company remains your responsibility, including the balance exceeding usual and customary rates (UCR).
- **SECONDARY INSURANCE**: Having more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. As a service we will gladly bill your secondary insurance company. **Any balance not paid by your secondary insurance company remains your responsibility.**

5% COURTESY ADJUSTMENT

This is our way of saying thank-you for maintaining your account in good-standing by paying your bill in full with minimal administrative overhead on our part. Only cash or check payments in full are eligible to receive the 5% courtesy adjustment. Payments with credit and debit cards are NOT eligible for the 5% courtesy adjustment. A 5% courtesy adjustment will not be given if we are managing your insurance, mailing statements, or otherwise administering your account. Your previous account balance must be zero to receive the 5% courtesy adjustment.

A finance charge of 18% annually (1.5% per month) will be applied to any balance held past 30 days. Returned checks are subject to a fee of $25.00 (per check). In the event that your account is not paid in full, you may be referred to a collection agency. You will be responsible for all fees incurred for collection of your bill.

Your appointment time has been reserved exclusively for you. Any change in your appointment affects many patients. **We respectfully ask that you provide 48 hours notice if you need to change an appointment.** Patients demonstrating consistent late cancelations or no-shows may be charged $25.00 for each missed appointment and/or may be dismissed from the practice.

I have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered. This agreement stays in force until changed in writing.

(Name of patient or responsible party ï PLEASE PRINT) (Signature) (Date)

Jacob O. Layer
FAMILY DENTISTRY

CONSENT TO DENTAL PHOTOGRAPHY

Patient Name:_____

In connection with dental services, which I am receiving at the office of Dr. Jacob O. Layer, DMD, PC, I agree and consent to allow the photographs taken before, during, and after completion of my dental treatments to be used for dental records, research, education, marketing, public relations, patient counseling, or other purposes.

I further agree and consent that the photographs relating to my dental care may be published and republished, either separately or in connection with each other in dental photo albums, professional journals, or dental books.

This consent can be revoked by me at any time in writing.

Date:_____

Patient's Signature:_____

Witnessed By:_____

□ Individual declined to sign

Jacob O. Layer, DMD, PC
p: (541) 734-0970 · f: (541) 734-2081 · 1485 E McAndrews Rd, Medford, OR 97504 · www.layerdental.com

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (ñHIPAAò), 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 received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that Jacob O. Layer, DMD has the right to change is *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Patient Name:_____ _____
(Please Print) (Relationship to Patient)

Signature:_____ _____
(Please Sign) (Date)

Do we have your permission to:

Leave a message on your answering machine	□ Yes	□ No
Confirm appointments	□ Yes	□ No
Remind you of any pre-medication (if Applicable)	□ Yes	□ No
Speak to household members concerning you dental care	□ Yes	□ No

Name	Relationship
Name	Relationship
Name	Relationship

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other:_____
(Please specify)

Jacob O. Layer DMD, PC
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 IT CAREFULLY.

If you have any questions about this notice, please contact the designated privacy officer of our office at 541-734-0970.
1485 E. McAndrews Rd
Medford, OR 97504

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician.

This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements**, as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Effective Date: March 23, 2013

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
3. **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **Military, Veterans, National Security and Intelligence**. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **Workers' Compensation**. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
7. **Public Health Risks**. We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
8. **Health Oversight Activities**. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **Law Enforcement**. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
11. **Coroners, Medical Examiners and Funeral Directors**. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.
12. **Information Not Personally Identifiable**. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
13. **Family and Friends**. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object.
14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Jacob O. Layer DMD, PC
1485 E. McAndrews Rd
Medford, OR 97504
541-734-0970

You will not be penalized for filing a complaint.

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that you are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health-care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.