Curt A. Warren, DDS – Endodontics, PC

Confidential Health History and Patient Information Form

Patient Name:_____ Cell:_____

Address:_____ Home:_____

City/State/Zip:_____ Work:_____

Date of Birth:_____ Sex: M F SSN#:_____

Referring Dentist:_____

Are you currently under the care of a physician? Y N If yes, please explain:_____

_____

Primary Care Physician:_____ Phone: _____

If female, are you pregnant: Y N What month?_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

High Blood Pressure	Cancer (type)_____	Immunocompromised
Diabetes (Type I / Type II)	Chemotherapy	Autoimmune Disorder
Joint Replacement	Radiation	TMJ Disorder
Heart Disease	Transplant	Headaches / Migraine
Heart Attack / Stroke	Kidney	Epilepsy / Seizures
Heart Valve Replacement	Liver	Hearing / Vision Impairment
Pacemaker	Gastrointestinal	Smell / Taste Impairment
Bleeding Disorder	Neural (Nerve)	Herpes
Blood Thinner	Hormonal / Endocrine	Other Infectious Disease
Penicillin Allergy	Thyroid	Psychiatric Care
Latex Allergy	Musculoskeletal	Addiction (alcohol, drugs)
Dental Anxiety	Osteoporosis	Smoking

Other Medical conditions not listed here:_____

_____

Other allergies:_____

Please list all current medications (or provide a list):_____

_____

How would you rate your overall health? Good Fair Poor

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Confidential Health History and Patient Information Form (continued)

Patient Name:_____

I, the undersigned, being the patient, or the parent, or the guardian of the above minor patient, consent after consultation to the performing of whatever procedure may be deemed necessary by the doctor. I authorize and request the administration of such drugs and/or anesthetics as deemed advisable by the doctor. I also understand that upon completion of root canal treatment, I will be referred to my dentist for permanent restoration of my tooth or teeth. I certify that the listed health history is correct and complete. I authorize the release of my treatment record as needed.

Signature:_____Date:_____

Additional Patient Information

Marital Status: Married Single Widowed Divorced

Insurance Coverage: Self Spouse Dependent

Subscriber Information (if other than self):

Name:_____

Date of birth:_____ SSN#:_____

Employer:_____

Emergency Contact:_____Relationship to patient_____

Emergency Contact Phone:_____Alternate Phone:_____

INITIAL TO ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES_____

Authorization to Release Information

Curt A. Warren DDS – Endodontics, PC is authorized to provide any insurance company, claim admininstrator, and/or qualified consulting health care professionals, information concerning health care, professional advice, treatment, or supplies provided.

Signature:_____Date:_____

Individuals You Authorize to Discuss Treatment Details with Our Office

_____ _____

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Financial Responsibilty Information & Agreement

In consideration of treatment rendered to the above named patient, I accept full financial responsibility. An insurance claim will be submitted electronically at completion of treatment as a convenience to the patient.

Payment is expected at the time services are rendered.

Payment arrangements, if needed, MUST be made prior to treatment. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection costs, court costs, and reasonable attorney fees.

I understand that the full estimated payment is due by completion of treatment._____ (initial)

Signature:_____Date:_____

IMPORTANT INFORMATION REGARDING THE FILING OF INSURANCE CLAIMS

You will be provided an ESTIMATE of insurance benefits prior to treatment. However, we cannot guarantee payment. There are differences in policy details and features, and depending on an insurance company's operating procedures, this information is not always disclosed to the provider.

- We may receive a payment from your insurance company that is different than the amount provided in your estimate. In this case, you will either receive a bill for the remainder, or you will receive a refund for the overpayment – depending on the situation.

It is ultimately the patient's responsibility to be aware of special stipulations or requirements in their policy (such as a waiting periods, frequency requirements for services, or any other relevant details). Again, this information is not always disclosed to the provider.

Important: On occasion, we may receive a significantly lower payment amount from your insurance company than was provided in your estimate. A claim may even be rejected unexpectedly. We will make every effort to avoid this scenario, but please be aware of this possibility.

Be advised: You may consult with your insurance company BEFORE TREATMENT to verify coverage yourself if the above described scenario will create a burden or difficulty for you. Treatment will only commence once you feel satisfied, informed, and comfortable with the details of your financial arrangements.

By signing this, you understand that you are fully responsible for any amount not paid by insurance.

Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

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

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

OUR LEGAL DUTY

We are required by applicable federal 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 Notice while it is in effect.

We reserve the right to change 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 made the changes. Before we make a significant change in our privacy practices, 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 Notice, 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 to you.

Payment: We may use and 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 written authorization, we cannot use or disclose your health information for any reason except for 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 heath 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 to object to such uses or disclosures. In the event of your incapacity or emergency, 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 inferences 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 Services: 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 victims of other crimes.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and their national security activities. We may disclose to correctional institution or law enforcement officials 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, 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 $.15 for each page, $13.00 per hour for staff time to locate and copy 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 the 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 fee 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, healthcare operations and certain other activities. 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 w 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 locations, 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 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 right, 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 to have us communicate with you by alternative locations, you may complain to us using the contact information list at the end of this Notice. You may also 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 the U.S. Department of Health and Human Services.

CONTACT INFORMATION

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