WELCOME

We are pleased to welcome you to our practice. Please fill out this form as completely as you can.
We look forward to working with you in maintaining your dental health.

(Please Print)

Name _____
First MI Last

Address _____

City, Sate, Zip _____

Home Phone _____ Cell_____

E-Mail Address _____
(Used to send reminders etc.)

Social Sec. # _____

Sex ☐M ☐F Age _____ Birthdate _____

Marital Status: Please Circle S M W D

Student? School/College _____

Place of Employment _____

Occupation _____ Bus Phone _____

Whom May We Thank for Referring You to Our Office?

_____

Notify in Case of Emergency _____

Home Phone _____ Other _____

Responsible Person if Patient is a Minor

Name _____
First MI Last

Address _____

City, State, Zip _____

Home Phone _____ Cell _____

E-Mail Address _____
(Used to send reminders, etc.)

Social Sec. # _____ Birthdate _____

Relationship to Patient _____

Place of Employment _____

Dental Insurance Information

Name of Insured _____

Soc. Sec. # _____ Birthdate _____

Place of Employment _____

Insurance Company _____

Group # _____ ID # _____

Ins. Co Phone # _____

Agreement to Pay for Services Rendered and Insurance Release
I agree to be responsible for payment of services rendered on my behalf or on behalf of my dependents. If I have insurance, this will serve as authorization to my insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature _____

HIPPA Privacy Policy Acknowledgment and Consent
By signing this form, you will consent to our use and disclosure of your protected health information to carry out **treatment, payment activities, and healthcare operations.** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is included with this form. We also reserve the right to change our privacy practices. We will issue a revised copy to you if such a change occurs. If you have any questions, you may contact our Privacy Officer at (918) 341-4844. You may revoke this Consent at any time with written notice to our Privacy Officer. Revocation of this consent will not affect any action taken in prior to us receiving your revocation. We reserve the right to decline any treatment to you upon revocation of this consent. I understand that by signing this form that I am giving my consent to your use and disclosure of the above mentioned protected healthcare information. You are entitled to receive a copy of our Notice of Privacy Practices.

Signature _____ Date _____

DENTAL HISTORY

Name of former Dentist _____ Date of last dental care _____ Last x-rays _____

Check if you have had problems with any of the following:

☐ Bleeding gums	☐ Bad breath	☐ Food collection between teeth	☐ Frequent headaches
☐ Sensitivity to cold	☐ Sensitivity to hot	☐ Sensitivity to sweet or sour	☐ Sensitivity when biting
☐ Loose Teeth	☐ Broken Fillings	☐ Sores or growths in mouth	☐ Clench or grind your teeth
☐ Difficult extraction	☐ Prolonged bleeding	☐ Head, neck or jaw injuries	☐ Clicking or popping jaw

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth and what would you change if anything? _____
_____

Have you ever experienced an adverse reaction during or with medical/dental treatment? ☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name _____ Phone _____Date of Last Visit _____
Have you ever had a serious illness or operation? ☐ Yes ☐ No Describe _____
Are you currently under a physician's care? ☐ Yes ☐ No Describe _____
Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check if you have had any of the following:

☐ AIDS/HIV Positive	☐ Cough up blood	☐ High Blood Pressure	☐ Rheumatic/Scarlet fever
☐ Anaphylaxis	☐ Diabetes	☐ Jaw Pain	☐ Shingles
☐ Anemia	☐ Epilepsy/Convulsions	☐ Kidney Disease or Malfunction	☐ Shortness of breath
☐ Arthritis	☐ Fainting/Seizures		☐ Skin rash
☐ Artificial Heart Valves	☐ Food allergies	☐ Leukemia	☐ Sleep Apnea
☐ Artificial Joints	☐ Glaucoma	☐ Liver disease	☐ Stroke
☐ Asthma	☐ Headaches	☐ Low Blood Pressure	☐ Surgical implant/replacem.
☐ Allergies (Seasonal)	☐ Heart murmur	☐ Material allergies (latex etc.)	☐ Swelling of feet or ankles
☐ Blood disease	☐ Heart problems Describe _____		☐ Thyroid disease or malfunction
☐ Cancer		☐ Mitral valve prolapse	
☐ Chemical dependency	_____	☐ Pacemaker	☐ Tobacco Habit
☐ Chemotherapy	☐ Hemophilia/Abnormal bleeding	☐ Psychiatric care	☐ Tonsillitis
☐ Circulatory problems		☐ Rapid weight change	☐ Tuberculosis
☐ Cortisone treatments	☐ Herpes	☐ Radiation treatment	☐ Ulcer/colitis
☐ Cough persistent	☐ Hepatitis A, B or C	☐ Respiratory disease	☐ Venereal disease

List any medications you are currently taking, if any

_____

_____

List any drug allergies, if any, or write "None"

_____

_____

AUTHORIZATION

I have reviewed the information on this medication questionnaire and it is accurate to the best of my knowledge. I understand that the above information will be used by the dentist and his staff to help determine appropriate and healthful dental treatment. I also understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist.

Signature _____ Date _____

R. Randall Haskins, DDS, MAGD, PLLC
Family Dentistry
1495 W. Blue Starr Drive
Claremore, OK 74017
(918) 341-4844 Fax (918) 341-4852
ClaremoreDentalCare.Com

OFFICE POLICY FOR PAYMENT AND INSURANCE ACCEPTANCE

Due to increased costs of mailing statements and in an effort to keep our costs as low as possible, we find it necessary to expect our patients to pay in full for services rendered at each appointment.

For your convenience, we offer the following methods of payment: Cash, Check, Visa, MC, CC, DISCOVER

If you do have insurance, as a service to you, we will file your primary insurance for you. You will be responsible for paying your deductible and any co-payment that you may have. We emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing of claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We will provide you with an estimate of what your fee will be based on the benefit information that your insurance company has provides to us. However, this is not a guarantee of benefits. We would recommend that you check with your insurance company to verify benefits.

Outstanding balances sixty (60) days or older will be assessed a late charge of 1.5% per month on the balance.
We allow sixty (60) days for payment from your insurance company, then at that time the total balance due becomes your responsibility. Failure to keep this account current may result in our office being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default of payment on this account, there could be collection costs, court costs or attorney fees incurred in attempting to collect on your current balance or any future outstanding account balances.

When our office schedules an appointment for you, we are reserving that time period exclusively for you. You are reserving the doctor's time and the staff's time for your appointment. If for any reason you need to change your appointment time, a minimum forty-eight (48) hour notice is required. If less than forty-eight (48) hours notice is given, we reserve the right to charge for that time.

We hope this policy will better serve you and avoid any misunderstandings. If you have any questions About the above policy, please do not hesitate to ask us. We are here to help you.

Thank you.

Signature _____ Date _____

Notice of Privacy Practices

R. Randall Haskins, DDS, MAGD, PLLC

Family Dentistry

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect and will remain in effect until we replace it. 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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. September 23, 2013

How we may use and disclose health information about you

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any audits, investigations, inspections, and credentialing, as necessary for other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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 information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.
Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.
Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.
Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.
Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.
Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 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 the U.S. Department of Health and Human Services.

Privacy Official Name and Contact Information:

Sheila H.
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Claremore, OK 74017
918-341-4844
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Sheila@ClaremoreDentalCare.com