PATIENT REGISTRATION

(Please Print)

DATE:________________

Patient Name: ____
Last first Middle

Patient Address: Street:____
City, State, Zip Code: ____________________________________

Birthdate:___________**Age:**______**Sex:** ( ) M ( ) F **Patient Social Security #** ____________

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Telephone: Home_________________Daytime or work Phone ____________________________

Employer________________________________**Occupation**______________________________

Account Information

Person Financially Responsible for Account: (Not your insurance company's Name)

NAME:____

ADDRESS:____

____

PHONE NUMBER_________________________**SAME AS ABOVE**____

Relationship to Patient: ( ) Self ( )Spouse ( ) Father ( )Mother ( )Guardian

IF PATIENT IS A MINOR:
Fathers Name: ____
Social Security #:_____________________________**Birthdate**___________________
Mothers Name:____
Social Security #:_____________________________**Birthdate**___________________

DENTAL INSURANCE : PRIMARY __________________________**GROUP #**______________
PRIMARY INSURANCE EMPLOYEE NAME: ______________________________________
INSUREDS SOCIAL SECURITY #___________________________**BIRTHDATE**__________
INSUREDS EMPLOYER:____
EMPLOYER ADDRESS____

SECONDARY INSURANCE:_____________________________**GROUP #**_________________
SECONDARY INSURANCE EMPLOYEE NAME: ______________________________________
SECONDARY INSUREDS SOCIAL SECURITY #___________________**BIRTHDATE**________
INSUREDS EMPLOYER:____
EMPLOYER ADDRESS____

Have you or any member of your family been a patient? ( ) YES ( ) NO

Whom may we thank for referring you?____

MEDICAL HISTORY

(PLEASE PRINT)

PATIENT:____

Last First Initial Preferred Name

SEX: ( ) M ( ) F BIRTHDATE:_______________ AGE:_________ WEIGHT:___________

PHYSICIANS NAME: ____ DATE OF LAST PHYSICAL:___________

Have you been under the care of a physician during the past two years? .... Yes ..... No
If yes, for what?____

Are you taking any medication at this time?...Yes...No If yes, please list name and dosage:_______________________
____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or substance?...Yes...No
If yes, What?____

Have you ever responded adversely to medical or dental treatment?...Yes... No If yes, explain:___________________
____

Indicate which of the following you have had, or have at present. Check All Boxes That Apply.

( ) Heart (surgery, disease, attack)
( ) Artificial heart valve
( ) Mitral valve prolapse
( ) Heart Murmur
( ) Congenital heart disease
( ) High Blood Pressure
( ) Heart Pacemaker
( ) Rheumatic Fever
( ) Arthritis/Rheumatism
( ) Swollen Ankles
( ) Stroke
( ) kidney trouble
( ) Artificial joints (hip, knee, etc)
( ) Diet (special/restricted)
( ) Cortisone Medication
( ) Eating Disorders

( )Ulcers
( ) Diabetes
( ) Thyroid Problems
( ) Glaucoma
( ) Contact lenses
( )Emphysema
( ) Chronic Cough
( ) Tuberculosis
( ) Asthma
( ) Hay Fever
( ) Latex Sensitivity
( ) Allergies or Hives
( ) Sinus Trouble
( ) Radiation Therapy
( ) Chemotherapy
( ) Tumors

( ) Hepatits A (infectious) B (serum) C
( )Venereal Disease
( ) A.I.D.S.
( ) HIV Positive
( ) Cold Sores/ Fever Blisters
( ) Blood transfusion
( ) Hemophilia
( ) Sickle Cell Disease
( ) Bruise Easily
( ) Liver disease
( ) Yellow Jaundice
( ) Neurological Disorders
( ) Epilepsy or seizures
( ) Fainting or Dizzy Spells
( ) Nervous/ Anxious
( ) Psychiatric/Psychological Care

( ) NONE OF THE ABOVE

Do you have any or have you had any disease, condition, or problem not listed? ....Yes....No If yes, explain____________
____

Please describe anything else we should know about your medical history _______________________
____

Woman: Are you: Pregnant?....Yes...No.... Nursing?...Yes...No.....Taking birth control pills?.....Yes.....No

In case of emergency, who should be notified?_______________________________ Phone_______________

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature____ Date____________

Michael R Leech DDS and Associates, Inc.
630 Lexington Ave
Mansfield, OH 44907
(419) 756-1110

FINANCIAL POLICY

Payment for services is due the time of the visit unless other arrangements have been made. We accept most traditional insurance policies. Patients with dental insurance must take care of their part not covered by the insurance at the time of treatment, including any deductibles and copayments. A finance charge of 1.8% per month will be charged on any balances 60 or more days past due. Any account turned over to a collection agency will be charged a 35 % processing fee, plus applicable court fees. We will be happy to discuss any special needs in the handling of your account. We accept cash, checks, or identified credit cards.

CANCELLATION POLICY

In order to serve our patients more efficiently, we request at least 24 hours advance notice be given if you are unable to keep your appointment. This will allow other patients to utilize that time reserved for you. Last minute cancellations, failed appoints, or no shows are subject to a $40 failed appointment fee. This fee is not payable by your insurance company. You will be responsible for this fee.

________________________________ **Date** ________________
Signature

Explanation of insurance

Dental benefit plans are made available to employees or members through companies, unions, and associations, and vary considerably from one plan to the next. The range of benefits depends solely on what the plan purchaser wishes to offer to employees or members. Some plans cover as little as 30% or as much as 100% of the fees for dental services. Most plans have a deductible and a maximum level of reimbursement. Some plans exclude certain types of services. A dental benefit plan helps you pay for the cost of your dental care. **You are financially responsible for the cost of all dental treatment provided to you, irrespective of your dental benefits.**

Due to the wide variety of plans, it is not possible for this office to know how your plan is designed and its limitations. The type of treatment you need and receive from this office is based on professional judgement and not whether or not the treatment is covered by a dental benefit plan. **It is important that you know how your dental plan is designed, its limitations, and reimbursement levels.**

The dental benefit plan is a contract between you, your employer, or plan sponsor, and a third- party (insurance company). If you direct the insurance company to pay its share directly to this office, you will receive credit for the amount and be billed for the balance. **We require any part not covered by your insurance, deductibles and co-payments, to be paid at the time of service**. Upon receipt of payment from the third- party, the office will reconcile the amount, and bill or refund any difference.

If your plan requires a pre-determination or pre-authorization, we will submit one for review by the third-party payer. However, please remember that the financial obligation is between you and this office, irrespective of what the third-party payer is responsible for you.

We will help you, to the best of our ability, to understand and process your insurance claims. However, **If you have questions regarding your dental plan, or a problem with reimbursement level, please contact your employer or insurance company.**

Michael R Leech DDS and Associates, Inc.

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. This Notice takes effect ____01/01/08____, 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. 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 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 to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information 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 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 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, 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 $0.15 for each page, $50 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 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 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, 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 Web site 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 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.

Contact Officer: Dr. Leech

Telephone: 419-756-1110 Fax: ______

E-mail: ______

Address: 630 Lexington Ave, Mansfield, OH 44907

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PRIVACY NOTICE ADDENDUM

Michael R Leech DDS and Associates, Inc.

EFFECTIVE September 24, 2014

-Patient information will not be sold or used for marketing or fundraising purposes without previous signed authorization by the patient.

-Patients will be informed if there are any financial conflicts of interest between this office and any products or services utilized within this practice or as part of treatment.

-Patients will be notified of any breach of information in a timely manner.

-If a patient personally pays for a procedure and asks that information about that procedure NOT be disclosed to their insurance company, and as long as the patient pays in full prior to the procedure, this office will not make the disclosure.

-This office does not retain patient health records in an electronic format, other than digital x-rays.

-Patient health records , other than digital x-rays , are not available in electronic format.

-Digital x-rays are available in print or electronically by email. However, email of digital x-rays is not secure or encrypted.

Michael R Leech DDS and Associates, Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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