Step 1 - Patient Registration - Personal Information:

First, Last _____ _____ ☐ Male ☐ Female
Home Address _____
City _____ State _____ Zip _____
Birthdate _____ ☐ Married ☐ Single
Home Phone # _____ Cell # _____ Work Phone # _____
E-mail Address _____ Medicaid # _____ Soc. Sec. # _____
I am a full time student ☐ School Name _____
Occupation _____
Referred by _____ Visit Reason _____

Emergency information (A relative NOT living with you):
Name _____ Phone # _____
Relationship To Guarantor (Person Responsible For Account)
Primary is ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other Preferred Provider _____

Step 2 - Patient Registration - Responsible Party Information:

☐ Add this patient member to an existing guarantor

Guarantor Information (Person Responsible For Account)
First, Last _____ _____
Address _____
City _____ State _____ Zip _____ Birthdate _____
Home Phone # _____ Work Phone # _____ E-mail _____
Soc. Sec. # _____ Driver's Lic. _____
Coverage ☐ Cash ☐ Single Ins. / PPO ☐ Dual Insurance ☐ Pre-paid/Capitation ☐ Medicaid

Step 3 - Patient Registration & Health History:

Primary Insurance Information
☐ Add New Carrier ☐ Select Existing Carrier
Carrier ID _____
Insurance Co. Name _____
Insurance Co. Address _____
City _____ State _____ Zip _____ Phone # _____
Group/Plan # _____ Union Local # _____
Eligibility Phone # _____

Primary Employer Information
☐ Add New Employer ☐ Select Existing Employer
Employer ID _____
Employer Name _____
Employer Address _____
City _____ State _____ Zip _____ Phone # _____

Step 4 - Patient Health History - Dental

Dental History Information

Previous Dentist Name _____

City_____ Phone # _____

How LONG SINCE you have seen a dentist? _____

Last COMPLETE dental exam date _____

Last FULL MOUTH X-RAYS date

Are you having PROBLEMS now? ☐ Yes ☐ No

If yes, please explain:

Do you wear DENTURES? (Partials or Full) ☐ Yes ☐ No

Are you unhappy with your dentures? ☐ Yes ☐ No

Have you any PERIODONTAL (GUM) treatments? ☐ Yes ☐ No

Do your gums BLEED, or feel TENDER, or IRRITATED? ☐ Yes ☐ No

Are your teeth SENSITIVE to hot, cold, sweets, or pressure? ☐ Yes ☐ No

Are you UNHAPPY with the appearance of your teeth? ☐ Yes ☐ No

Are you aware of GRINDING or CLENCHING your teeth? ☐ Yes ☐ No

Do you have HEADACHES, EARACHES, or NECK PAINS? ☐ Yes ☐ No

Do you have LOOSE, TIPPED or SHIFTING teeth? ☐ Yes ☐ No

Have you worn BRACES on your teeth? (ORTHODONTICS) ☐ Yes ☐ No

Do you have DISCOLORED teeth that bother you? ☐ Yes ☐ No

Would you like your smile to LOOK BETTER or DIFFERENT? ☐ Yes ☐ No

Do you have problems with teeth/fillings BREAKING? ☐ Yes ☐ No

Do you REGULARLY use DENTAL FLOSS? ☐ Yes ☐ No

Are you aware of being ALLERGIC TO or reacting adversely to any medications or substances?

☐ Yes ☐ No

If yes, please list:

Step 5 - Patient Health History - Medical

Medical History Information

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, please explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	_____
Are you on a special diet?	◯ Yes ◯ No	_____
Do you use tobacco?	◯ Yes ◯ No	_____
Do you use controlled substances?	◯ Yes ◯ No	_____

Women: Are you:
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives?? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following? ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics ◯ Pet Dander
◯ Other If yes, please explain: _____

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

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

Additional 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.

X _____
Signature of patient (or parent/guardian if minor) Date

JOSEPH ZIMMER D.D.S.

FINANCIAL POLICY

We strive to maintain a high quality, personalized dental practice committed to excellence and affordability. Our goal when treating you is to involve you, as an active participant in your dental care. For us to provide quality, efficient, and affordable services, we ask you to keep your schedule appointments and pay at the time of service. This will reduce billing and fee collecting costs and ultimately reduce fees charged to you.

PAYMENTS

Fees are established per services provided at your appointment and payment is due at the time of service unless prior arrangements are made. We accept cash, checks, Visa, MasterCard, Amex and Discover debit/credit cards. We also accept outside financing through Care Credit. Please let us know if you are interested in applying before your treatment is scheduled.

We do accept payment at the time of service although if payment arrangements are necessary, they must be made prior to your dental appointment. We would need a credit card on file in order to run auto-monthly payments, due at the end of the month. Our contract must be signed before treatment starts.

Any past due balances owing after 120 days will be sent to collections unless other arrangements have been agreed upon with us. Should your account be sent to collections, you will be obligated to pay all reasonable collection expenses, including the fees charged to our office by the collection agency, any interest/finance fees, past-due fees, and/or attorney and court costs related to your account.

INSURANCE

To prevent any misunderstanding we want our patients to know that insurance policies vary and that it is ultimately your responsibility to pay for the services provided, regardless of your dental insurance coverage. We always advise our patients to be involved and to get familiar with their dental benefits by calling customer service. This office will do everything we can to help our patients recover benefits and, in fact, as a courtesy to you, we will bill your insurance directly. We can assist you in estimating the amount your insurance should cover. Occasionally, some insurance companies make payments directly to the patient. If this is the case please forward any checks and explanation of benefits sent to you by your insurance company to our office so we may post these payments correctly to your account in a timely fashion. This will help us determine the amount insurance is covering and allow your statement to reflect the amount you owe more accurately. Your adherence to our policy greatly improves our ability to serve you.

DISCOUNTS FOR THE UNINSURED

We offer a 5% discount if you're uninsured and pay at the time of service with a check or cash.

CANCELLATION OR MISSED APPOINTMENTS

We realize that your schedule may change and that it may be necessary for you to change/cancel your reserved appointment. We kindly request that you notify our office as soon as possible by a phone call in these circumstances. The $75 charge per hour may be assessed to your account for missed or canceled appointments with less than a 24-hour notice. Please understand we strive to run on time and appreciate you doing as well.

We understand that you have a choice in your dental care and appreciate your trust in us. Thank you.

I understand and agree to the terms of this financial policy:

Print Name: _____ Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

[45 CFR 164.520]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

OCR HIPAA Privacy December 3, 2002 Revised April 3, 2003 C How the covered entity may use and disclose protected health information about an individual.

- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

Print Name: _____ Signature: _____ Date: _____

If minor, relationship to patient: _____ Other Family Members Applies To: _____