

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle: _____
Patient is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____	Last Name: _____
Address: _____	Address 2: _____
City, State, Zip: _____	
Home Phone: _____	Work Phone: _____ Ext: _____
Cell Phone: _____	Email: _____
Birth Date: ___/___/___	Soc. Sec: _____ Driver's License: _____
<input type="checkbox"/> Responsible Party is also Policy Holder for patient <input type="checkbox"/> Primary Ins. Holder <input type="checkbox"/> Secondary Ins.	

Patient Information:

Address: _____	Address 2: _____
City, State, Zip: _____	
Home Phone: _____	Work Phone: _____ Cell Phone: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Birth Date: ___/___/___	Age: _____ Soc. Sec: _____
Driver's License: _____	Email Address: _____

Insurance Information:

<u>Primary Insurance</u>	
Name of Insured: _____	
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insured Soc. Sec: _____	Insured Birth Date: ___/___/___
Employer: _____	
Insurance Company: _____	
Group Number: _____	Policy Number: _____
<u>Secondary Insurance</u>	
Name of Insured: _____	
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Insured Soc. Sec: _____	Insured Birth Date: ___/___/___
Employer: _____	
Insurance Company: _____	
Group Number: _____	Policy Number: _____

How did you hear about Boyett Health Services?

TV Newspaper Yellow Pages Email
 My Employer (Name: _____) Friend/Family (Name: _____)

MEDICAL HISTORY

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, Physician Name: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No **If yes, please list in medication section at bottom of page.**
- Are you on a special diet? Yes No If yes, please explain: _____
- 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

Please circle yes or no if you have or have had any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive			Diabetes			Hemophilia			Renal Dialysis		
Artificial Heart Valve			Drug Addiction			Hepatitis B or C			Rheumatic Fever		
Artificial Joint			Easily Winded			Herpes			Rheumatism		
Asthma			Emphysema			High Blood Pressure			Scarlet Fever		
Breathing Problem			Epilepsy or Seizures			Irregular Heartbeat			Sickle Cell Disease		
Bruise Easily			Excessive Bleeding			Kidney Problems			Stroke		
Cancer			Fainting/Dizziness			Leukemia			Swelling of Limbs		
Chemotherapy			Frequent Headaches			Liver Disease			Tuberculosis		
Chest Pains			Glaucoma			Lung Disease			Tumors or Growths		
Cold Sores/Fever Blisters			Heart Attack/Failure			Pain in Jaw Joints			Ulcers		
Congenital Heart Disorder			Heart Murmur			Psychiatric Care			Yellow Jaundice		
Convulsions			Heart Pace Maker			Radiation Treatments					
			Heart Trouble/Disease								

Have you ever had any serious illness not listed above? Yes No If Yes, please explain: _____

Please list all medications, along with name, strength and how it is taken: _____

Please list your past health problems: _____

Please list past surgeries: _____

Please list all known allergies: _____

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____



Dental Treatment Consent Form

1. **Drugs, Latex, and Medications**

I understand that latex gloves, antibiotics, local anesthetics and other medications can cause allergic reactions, even life threatening reactions. Also, some antibiotics can interfere with birth control pills. Epinephrine in local anesthetics can cause temporary increase in heart rate, and in rare cases may be dangerous.

2. **Fillings, Crown, and Unanticipated Root Canals**

We **do not treat teeth with amalgam (metal) fillings**. We use composite material for all operative restorations (fillings), if my insurance does pay for composite fillings, I will be responsible for the payment. The patient or responsible party should be familiar with the benefits provided by their insurance carrier. Please review your booklet or contact your insurance carrier if you have any questions. Some teeth may need a root canal even after a simple filling. Fillings and crowns are preformed to treat diseased teeth, and a small percentage of these teeth end up needing a root canal after the filling or the crown is done. The root canal is a separate procedure and a separate fee.

3. **Root Canals Can Fail**

Root Canals have a high success rate but they can fail and may require additional or specialized treatment. The tooth may even have to be extracted in some cases.

4. **Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings**

All these dental procedures are esthetically pleasing. However, they may chip or break at some point in the future. The patient is responsible for repairs or remakes. Sometimes it is not possible to match natural teeth exactly with artificial teeth. I further understand that prepping the tooth or teeth for crowns or veneers, as well as, wearing temporary crowns may cause irritation, swelling and discoloration of the gums and during the temporary phase teeth may be sensitive to cold. I understand these temporary crowns will be worn until the lab has processed my permanent crowns or veneers and the temporary crowns or veneers may come off easily and I must be careful to ensure that they are kept on until my permanent teeth are delivered. Lab crowns and veneers may not fit properly requiring additional tooth preparation and impressions. These additional steps will be at no cost to me unless I have changed the treatment plan. Once a crown, veneer or filling has been done the color cannot be changed. You will be asked your preference of the tooth color prior to the processing of the teeth. Boyett Health Services only places composite fillings, not amalgams (silver). If there are differences in coverage by your insurance carrier relating to what particular material is used, you will be responsible for the difference (see #2 above).

5. **Gum Treatment and Cleanings**

When regular cleanings are missed, or daily hygiene is improperly done, periodontal disease can result, this is the destruction of the bone that supports my teeth. I understand if I have periodontal disease, I will need a more intensive therapy than a regular cleaning. I understand that a treatment plan will be made addressing the treatments that I might need. If I do not wish to follow the treatment plan, I will be asked to sign a refusal of treatment form. All new patients to our practice are required to undergo a complete dental exam, a cleaning with a full series of x-rays and a periodontal evaluation.

6. **Extractions and Surgery**

I understand that all dental extractions or surgeries carry risks. If surgery is needed those risks will be explained to me.

7. Fee for Additional or Specialty Care

I understand that I may require treatment beyond what was planned. Such as when a tooth is crowned and needs a root canal. Also, I may be referred to a specialist for additional care. I agree to be financially responsible for the additional or specialty care.

8. Hygiene Appointments

If I am more than 15 minutes late for my hygiene appointment, I will either take the time remaining for my appointment or reschedule and pay a broken appointment fee.

9. Adequate time must be allowed for dental treatment

We reserve the right to reschedule your appointment if you are late for your dental appointment. Please arrive for your dental appointment at least 10 minutes early so that we are able to begin your appointment on time. If, during the course of treatment it is determined that additional procedures are needed and there is not a sufficient time remaining to complete all procedures the patient may be asked to schedule a future appointment to complete the work.

10. Dental Treatment Can be Complicated

Treatment can be complicated and while we try to anticipate any potential changes to a treatment plan in advance, we may not be able to realize some problems with teeth and the surrounding tissues until treatment has begun. If at this point additional treatment is needed we will inform you. We strive to stay on schedule, but unforeseen complications do arise from time to time and we ask your patience during those times.

11. Family Members in Treatment Areas

We have limited amount of space in the treatment areas of our office. Our facilities do not allow for non-patients to be present chair side. One adult may accompany a minor to the treatment area on their first visit but on subsequent visits the minor will be accompanied by the dental assistant or hygienist. We cannot be responsible for managing children that are with adults that are undergoing treatment. Our services require that the full attention of the staff and doctor be directed toward the patient.

12. Limitations of Insurance Coverage

Insurances may not cover every procedure that we recommend. Some examples include: Nitrous Oxide, temporary dentures, removal of crowns or bridges, bleaching or cosmetic work. I understand what may be quoted as my portion (co-payment), is only an estimate. I agree to be financially responsible for what insurance does not cover, this includes the yearly deductible. If you have a current dental carrier, please bring your policy book with you on your first visit. If I am uninsured, I agree to be responsible for all dental charges at the time of service. This office offers, Care Credit, we accept cash, credit cards, debit cards and checks.

13. Filing of Dental Insurance for the Patient

We routinely file insurance claims for the patient as a courtesy. The patient is still fully responsible for the payment of all charges incurred with the office. If there are discrepancies in the amount that the insurance says they will pay and what they actually pay, it is my responsibility to work it out with my insurance company. We will provide you with the explanation of benefits from your insurance carrier at your request. If this occurs, I will then be responsible for the payment of all fees not paid by my insurance carrier.

14. My photo is required and is part of my chart; I agree to allow this photo.

I do not expect guarantees in dental care. I have read this form and consent to treatment.

Patient Signature_____

Date____/____/____

Witness_____



PEDIATRIC DENTISTRY

On occasion we encounter pediatric patients that have an unusual fear of dental procedures. The policy of this office is as follows:

We will explain and comfort the patient and push forward with treatment until resistance is met. We will then discontinue the treatment and reschedule the child for another appointment.

We will follow the same procedure with each appointment and push until resistance is met.

Each visit that we are unable to complete the scheduled treatment there will be an office visit fee of \$40.00.

This fee will be the responsibility of the parent or care giver of that patient. Insurance will not cover a visit when work was not completed.

This approach to handling unusual fear of the dentist will help desensitized the pediatric patient of their fear and forms a lasting relationship with the dentist and staff.

At any time if this arrangement and approach to handling the fear becomes a problem for the parent or care giver we will be glad to refer the patient to a pediatric dentist.

I agree to the above policy.

Date ___/___/___

ALABAMA NOTICE FORM

Boyett Health Service, Inc. (BHS)
2131 Military Street South
Hamilton, AL 35570
205-921-0893

Notice of Dentist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW DENTAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

BHS may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Healthcare Operations*”
 - Treatment is when BHS provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when BHS consults with another health care provider, such as your family physician or another dentist.
 - Payment is when BHS obtains reimbursement for your healthcare. Examples of payment are when BHS discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.
- “*Use*” applies only to activities within BHS such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of BHS such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

BHS may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when BHS is asked for information for purposes outside of treatment, payment or health care operations, BHS will obtain an authorization form you before releasing this information.

You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

BHS may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse*- If BHS is treating a child and suspects that child to be a victim of child abuse or neglect, they are required to report the abuse or neglect to a duly constituted authority.
- *Adult and Domestic Abuse*- If BHS has reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, the doctor must report this belief to the appropriate authorities.
- *Health Oversight Activities*- If the Alabama Board of Examiners in Dentistry is conducting an investigation into BHS, then your doctor is required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings*- If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and will not be released information without the written authorization of you or your legally appointed representative or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety*- BHS may disclose PHI to the appropriate individuals if the therapist believes in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
- *Worker's Compensation*- BHS may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's rights and Dentist's Duties

Patient's Rights:

- *Right to Request Restrictions*- You have the right to request restrictions on certain uses and disclosures of PHI. However, BHS is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*- You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, BHS will send your bills to another address.)

- *Right to Inspect and Copy*- You have the right to inspect or obtain a copy (or both) of PHI in BHS and billing records.
- *Right to Amend*- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your dentist may deny your request. On your request, your dentist will discuss with you the details of the amendment process.
- *Right to an Accounting*- You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy*- You have the right to obtain a paper copy of the notice from your dentist upon request, even if you have agreed to receive the notice electronically.

Dentist Duties:

- BHS is required by law to maintain the privacy of protected health information regarding you and to provide you with notice of my legal duties and privacy practices with respect to PHI.
- BHS reserves the right to change the privacy policies and practices described in this notice. Unless BHS notifies you of such changes, however, BHS is required to abide by the terms currently in effect.
- If BHS revises their policies and procedures, they will notify you by mail.

V. Complaints

If you are concerned that BHS has violated your privacy rights, or you disagree with a decision your dentist has made about access to your records, you may contact Linda Purser, office manager at 205-921-0893.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

Signature _____ Date ____/____/____

AUTHORIZATION FOR THE RELEASE
OF PATIENT INFORMATION

Please understand that it may be necessary for us to release some or all of the information contained in your medical records to other physicians, nurses, and/or healthcare providers. At times, other providers assist us assessing a patient's condition, screening for potential problems or providing consultation under certain circumstances. All healthcare providers are required by law to keep your information confidential.

Due to the increased awareness of quality care it may be necessary to disclose information regarding your care to healthcare agencies, both private and governmental. Your insurance company and/or your self-insured employer are such agencies. Regarding the information going to your employer other than information needed to verify your insurance coverage; the data released will consist of statistical information only.

Also, at times it may be necessary for the physician/healthcare provider to contact you regarding your healthcare issues, if you are unavailable or cannot be reached:

_____ I do not wish to have test results or other medical information released to any person other than myself.

_____ I do wish to have test results and other medical information released to the following person(s) (these individuals are people other than medical personnel):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

It is the responsibility of the patient to notify this office of any changes to the above information if changes do occur. The patient must fill out another authorization with this new information.

Patient Signature

Date

Printed Name

Social Security Number

Witness