Basin Park Dental
Kenneth Tirone, DDS

Patient Registration

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM. IT WILL ENABLE US TO HELP YOU MORE EFFECTIVELY. IF YOU HAVE QUESTIONS AT ANY TIME, PLEASE LET US KNOW. WE ARE HAPPY TO HELP.

1 PATIENT INFORMATION

Name:
Date: Date of Birth:
Social Security #:
Address:
City:
State: Zip:
Sex: ❑ Male ❑ Female Age:
Patient Employer/School:
Occupation:
❑ Married ❑ Single ❑ Widowed ❑ Separated ❑ Minor
If under 18, Parents:
Spouse's Name:
Date of Birth:
SS#:
Spouse's Employer:
Referred by:

2 DENTAL INSURANCE

Person Responsible for account:
SS#: Date of Birth:
Insurance Co:
Employer of Insured:
Group #:
Is patient covered by additional insurance? ❑ Yes ❑ No
Subscriber's Name:
SS#: Date of Birth:
Insurance Co:
Group #:
PRIVACY PRACTICES ACKNOWLEDGEMENT I have been offered the Notice of Privacy Practices/HIPAA and have had the opportunity to review it. **SIGNATURE:**

3 CONTACT INFORMATION

Home ( )	Work ( )	Ext.	Cell ( )
Email:			
Spouse's Work ( )	Best time and place to reach you:		
IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in you household)			
Name:	Relationship:		
Home ( )	Work ( )	Ext.	

4 DENTAL HISTORY

Date of last dental visit:	Date of last dental x-rays:
How often do you get your teeth cleaned:	
How often do you brush:	How often do you floss:
What are your dental concerns/questions:	
Please indicate if you have had any of the following:	
❑ Jaw pain	❑ Grinding teeth
❑ Bad breath	❑ Loose teeth/broken fillings
❑ Tobacco use	❑ Periodontal treatment
❑ Clicking or popping jaw	❑ Sensitivity to heat
❑ Food collection between teeth	❑ Mouth sores
❑ Orthodontics/braces At what age?	❑ Missing teeth If so, are you interested in learning about replacement? ❑ Yes ❑ No
Are you interested in learning more about cosmetic dentistry options? ❑ Yes ❑ No	

5 Medical History

Physician Name: Date of last visit:

Please indicate if you have had any of the following:

❑ AIDS/HIV	❑ Congenital Heart Lesions	❑ Jaundice	❑ Sinus Trouble
❑ Anemia	❑ Cortisone Treatments	❑ Jaw Pain	❑ Skin Rash
❑ Arthritis, Rheumatism	❑ Cough, Persistent/Bloody	❑ Kidney Disease	❑ Special Diet
❑ Artificial Heart Valves	❑ Diabetes	❑ Liver Disease	❑ Stroke
❑ Artificial Joints	❑ Emphysema	❑ Low Blood Pressure	❑ Swollen Feet/Ankles
❑ Asthma	❑ Epilepsy	❑ Mitral Valve Prolapse	❑ Swollen Neck Glands
❑ Back Problems	❑ Fainting/Dizziness	❑ Nervous Problems	❑ Thyroid Disease
❑ Bleeding Abnormally with extractions or surgery	❑ Glaucoma	❑ Pacemaker	❑ Tonsillitis
	❑ Headaches	❑ Psychiatric Care	❑ Tuberculosis
❑ Blood Disease	❑ Heart Murmur	❑ Radiation Treatment	❑ Tumor or growth on head or neck
❑ Cancer	❑ Heart Problems	❑ Respiratory Disease	
❑ Chemical Dependency	❑ Hepatitis Type_____	❑ Rheumatic Fever	❑ Ulcer
❑ Chemotherapy	❑ Herpes	❑ Scarlet Fever	❑ Venereal Disease
❑ Circulatory Problems	❑ High Blood Pressure	❑ Shortness of Breath	❑ Weight loss, unexplained

Do you take antibiotic premedication for dental appointments? ❑ Yes ❑ No Medication Prescribed:
If applicable, do we have your permission to leave a phone message to remind you to premedicate? ❑ Yes ❑ No
Do we have your permission to leave a phone message to confirm your appointment? ❑ Yes ❑ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: Date:

6 Medications/Allergies

List any medications you are currently taking and the correlating diagnosis:

Please indicate if you have any allergies to the following:

❑ Aspirin	❑ Codeine	❑ Iodine	❑ Latex	❑ Local Anesthetic	❑ Penicillin	❑ Sulfate
❑ Barbiturates (sleeping pills)		❑ Other:				

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.

NOTICE OF PRIVACY POLICY/HIPAA

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 April 14, 2003, 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 and disclose your health information to a physician or other healthcare provider providing treatment 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.

Payment: We may use and disclose your health information to obtain payment for services we provide you. We may also disclose your health information to another health care provider or entity that is subject to federal Privacy Rules for its payment activities.

On 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Public Benefit: We may use or disclose your medical information when we are required to do so by law for the following purposes deemed to be in the public interest or benefit: as required by law; for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury; to report adult abuse,

neglect, or domestic violence; to health oversight agencies; in response to court and administrative orders and other lawful processes; to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person; to coroners, medical examiners, and funeral directors; to an organ procurement organization; to avert a serious threat to health or safety; in connection with certain research activities; to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities; to correctional institutions regarding inmates; and, as authorized by state worker's compensation laws.

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards or letters.

PATIENTS 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. You may also request access by sending us a letter to the address at the end of this notice. 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.

Restrictions: You have the right to request that we place additional restrictions on our use of 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 with the U.S. Department of Health and Human Services. 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.