impression
dental care

New Patient Registration Form

DATE	TITLE	FIRST NAME	LAST NAME
	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.		

Patient Information

HOME ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		MOBILE	NUMBERS OK TO LEAVE MESSAGE ☐ Hm ☐ Wk ☐ Cell	
SOCIAL SECURITY NO.	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
DRIVER'S LICENSE	EMAIL		☐ I would like to receive correspondences via email/mail		
EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Working/Unemployed				STUDENT STATUS ☐ Full Time ☐ Part Time	
PROFESSION	PLACE OF EMPLOYMENT			NAME OF SCHOOL	

☐ Primary Ins. Policy holder ☐ Secondary Ins. Policy holder ☐ Responsible Party is also Policy Holder for Patient

Responsible Party (if someone other than the patient)

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.	FIRST NAME		LAST NAME		
HOME ADDRESS			CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		MOBILE	NUMBERS OK TO LEAVE MESSAGE ☐ Hm ☐ Wk ☐ Cell	
SOCIAL SECURITY NO.	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
DRIVER'S LICENSE	EMAIL		☐ I would like to receive correspondences via email/mail		
EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Working/Unemployed				STUDENT STATUS ☐ Full Time ☐ Part Time	
PROFESSION	PLACE OF EMPLOYMENT			NAME OF SCHOOL	

Who may we thank for your referral?

☐ Friend/Patient	☐ Newspaper/Magazine	☐ Radio/TV	☐ Lecture/Seminar	☐ Special Event
☐ Professional Referral	☐ Online Search	☐ Brochure/Flyer	☐ Direct Mail	☐ Other

NAME OF REFFERRAL SOURCE

Consultation Notes (office use only):

MEDICAL ALERTS:

DISCUSSION:

NEXT VISIT:

MEDICAL HISTORY

Chief Complaints				
Primary Concerns	1st Onset Date:	Triggered by:	Worsened by:	Consult/Treatment History:
1.				
2.				
3.				

Medical History		Date(s)	Explanation
Are you under a physician's care?	□ Y □ N		
PHYSICIAN NAME PHONE			
Have you been hospitalized or had any operation?	□ Y □ N		
Have you ever had a serious head or neck injury?	□ Y □ N		
Are you taking any medications, pills or drugs?	□ Y □ N		
Do you take or have taken Phen-Fen or Redux?	□ Y □ N		
Are you on special diet?	□ Y □ N		
Do you use tobacco (pipe, cigar, smoke, vape or chew)?	□ Y □ N		
Do you use controlled substances?	□ Y □ N		
Women: are you □ Pregnant □ Trying to get pregnant □ Nursing □ Taking oral contraceptives □ On hormone replacement therapy			
Are you allergic to any of the following? □ Aspirin □ Penicillin □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other:_____ Pharmacy of Choice: _____ Phone: _____			

Do you have, or have you had any of the following?					
ADD/ADHD	□ Y □ N	Easily Winded	□ Y □ N	Mitral Valve Prolapse	□ Y □ N
AIDS/HIV Positive	□ Y □ N	Emphysema	□ Y □ N	Muscle Aches/Pains	□ Y □ N
Alzheimer's Disease Positive	□ Y □ N	Epilepsy or Seizures	□ Y □ N	Nasal/Sinus/Ear Issues	□ Y □ N
Anaphylaxis	□ Y □ N	Excessive Bleeding	□ Y □ N	Nutritional Disorder	□ Y □ N
Anemia	□ Y □ N	Excessive Thirst	□ Y □ N	Parathyroid Disease	□ Y □ N
Angina	□ Y □ N	Fainting Spells/Dizziness	□ Y □ N	Parkinson's	□ Y □ N
Anorexia	□ Y □ N	Frequent Diarrhea	□ Y □ N	Psoriasis	□ Y □ N
Arthritis	□ Y □ N	Genital Herpes	□ Y □ N	Psychiatric (Depression/Anxiety)	□ Y □ N
Arthritis/Gout	□ Y □ N	Glaucoma	□ Y □ N	Radiation Treatments	□ Y □ N
Artificial Heart Valve	□ Y □ N	Hay Fever	□ Y □ N	Recent Weight Loss	□ Y □ N
Artificial Joint	□ Y □ N	Headaches	□ Y □ N	Renal Dialysis	□ Y □ N
Asthma	□ Y □ N	Heart Attack/Failure	□ Y □ N	Rheumatic Fever	□ Y □ N
Blood Disease	□ Y □ N	Heart Murmur	□ Y □ N	Rheumatism	□ Y □ N
Blood Transfusion	□ Y □ N	Heart Pacemaker	□ Y □ N	Scarlet Fever	□ Y □ N
Bruise Easily	□ Y □ N	Heart Trouble/Disease	□ Y □ N	Shingles	□ Y □ N
Bulimia	□ Y □ N	Hemophilia	□ Y □ N	Sickle Cell Disease	□ Y □ N
Cancer	□ Y □ N	Hepatitis A	□ Y □ N	Spina Bifida	□ Y □ N
Chemotherapy	□ Y □ N	Hepatitis B or C	□ Y □ N	Stomach/Intestinal Disease	□ Y □ N
Chest Pains	□ Y □ N	Herpes	□ Y □ N	Stroke	□ Y □ N
Cold Sores/Fever Blisters	□ Y □ N	High Blood Pressure	□ Y □ N	Swelling of Limbs	□ Y □ N
Congenital Heart Disorder	□ Y □ N	Hives or Rash	□ Y □ N	Thyroid Disease	□ Y □ N
Convulsions	□ Y □ N	Hypoglycemia	□ Y □ N	TMJ (Jaw/Joint/Facial Pain)	□ Y □ N
Cortisone Medicine/Steroids	□ Y □ N	Irregular Heartbeat	□ Y □ N	Tonsillitis/Enlarged Tonsils	□ Y □ N
Crohn's	□ Y □ N	Kidney Problems	□ Y □ N	Tuberculosis	□ Y □ N
Diabetes	□ Y □ N	Leukemia	□ Y □ N	Tumors or Growths	□ Y □ N
Digestive Problems	□ Y □ N	Liver Disease	□ Y □ N	Stomach/GI Ulcers	□ Y □ N
Dementia	□ Y □ N	Low Blood Pressure	□ Y □ N	Venereal Disease	□ Y □ N
Drug Addiction	□ Y □ N	Lung Disease	□ Y □ N	Yellow Jaundice	□ Y □ N
If yes to any of the above, note date(s) and explain symptoms & treatment received or receiving:					
Other illness not listed above, note date(s) and explain symptoms & treatment received or receiving:					

DENTAL HISTORY

Habits History		Date(s)	Explain
Tongue Thrust/Mouth Breathing	□ Never □ Past □ Current		
Tongue Biting	□ Never □ Past □ Current		
Lower Lip Biting/Sucking	□ Never □ Past □ Current		
Cheek Biting	□ Never □ Past □ Current		
Nail, Pencil, Object Biting	□ Never □ Past □ Current		
Thumb/Finger Sucking	□ Never □ Past □ Current		
Chewing Gum	□ Never □ Past □ Current		
Soft Drinks	□ Never □ Past □ Current		
Other: _____	□ Never □ Past □ Current		

Dental Treatment History		Date(s)	Explain
Smile Makeover/Full Mouth Restoration Teeth	□ Never □ Past □ Current		
Dentures	□ Never □ Past □ Current		
Night Guard	□ Never □ Past □ Current		
Sports/Athletic Guard	□ Never □ Past □ Current		
Gum (Periodontic) Treatment	□ Never □ Past □ Current		
Oral Surgery	□ Never □ Past □ Current		
Wisdom Teeth Extraction	□ Never □ Past □ Current		
Whitening Tray Use	□ Never □ Past □ Current		
Jaw Surgery	□ Never □ Past □ Current		

TMJ & Sleep Apnea Treatment History		Date(s)	Explain
Snoring Appliance	□ Never □ Past □ Current		
Sleep Apnea Appliance	□ Never □ Past □ Current		
CPAP	□ Never □ Past □ Current		
TMJ/Splint Therapy	□ Never □ Past □ Current		

Orthodontic Treatment History		Date(s)	Explain
Clear Aligners (Invisalign, ClearCorrect)	□ Never □ Past □ Current		
Braces (traditional)	□ Never □ Past □ Current		
Functional Appliance	□ Never □ Past □ Current		
Expansion Appliance	□ Never □ Past □ Current		
Cervical Headgear	□ Never □ Past □ Current		
Reverse Pull Headgear	□ Never □ Past □ Current		
Retainers □ Wire & Acrylic □ Clear Tray Type	□ Never □ Past □ Current		
Myofunctional Therapy	□ Never □ Past □ Current		
Teeth Extracted for Braces	□ Never □ Past □ Current		
Reason for orthodontic treatment: □ Cosmetic □ Restore Bite □ TMJ/Airway			

Imaging History	Date	Reason
Intraoral X-rays		
Panoramic X-rays		
Cone Beam CT		
MRI		
Medical CT		
Other X-rays		

Mouth, Teeth & Gum Problems		Date(s)	Explain
Clenching	□ Never □ Past □ Current		
Grinding (Bruxism)	□ Never □ Past □ Current		
Difficulty Chewing	□ Never □ Past □ Current		
Difficulty Finding Stable Bite	□ Never □ Past □ Current		
Diet Limited to Liquids/Soft Foods	□ Never □ Past □ Current		
Bleeding Gums	□ Never □ Past □ Current		
Receding Gums	□ Never □ Past □ Current		
Swollen/Red Gums	□ Never □ Past □ Current		
Painful Gums	□ Never □ Past □ Current		
Sore Teeth	□ Never □ Past □ Current		
Loose Teeth	□ Never □ Past □ Current		
Painful Teeth (Spontaneous)	□ Never □ Past □ Current		
Sensitive Teeth □ Cold □ Hot □ Sweet	□ Never □ Past □ Current		
Broken/Chipped Teeth	□ Never □ Past □ Current		
Broken/Chipped Restorations	□ Never □ Past □ Current		
Mouth Sores: □ Herpes/Cold Sores □ Aphthous Ulcer/Canker Sore	□ Never □ Past □ Current		
Other Problems: _____	□ Never □ Past □ Current		

Smile Problems		If yes, please elaborate
Upper front teeth too long	□ Y □ N	
Upper front teeth too short	□ Y □ N	
Front teeth have spaces between them	□ Y □ N	
Front teeth crooked	□ Y □ N	
Front teeth worn, chipped or fractured	□ Y □ N	
Teeth have yellow or brown discolorations	□ Y □ N	
Gums show too much when I smile	□ Y □ N	
Not enough teeth show when I smile	□ Y □ N	

SLEEP SCREENING SUPPLEMENT

Sleep Disorder Assessment		
1. Has anyone told you that you stop breathing while asleep?	□ Y □ N	4
2. Have you ever been involved in any type of accident because you nodded off or fell asleep?	□ Y □ N	3
3. Have you ever nodded off or fallen asleep while driving?	□ Y □ N	3
4. Have you woken up suddenly gasping for air, heart racing or with shortness of breath?	□ Y □ N	3
5. Do you grind your teeth?	□ Y □ N	3
6. Do you snore or has someone ever told you that you snore?	□ Y □ N	3
7. Does anyone in your family have history of snoring or sleep apnea?	□ Y □ N	3
8. Do you feel tired or sleepy throughout the day?	□ Y □ N	2
9. Does it take you less than 10 minutes to fall asleep?	□ Y □ N	2
10. Does it take you more than 20 minutes to fall asleep?	□ Y □ N	2
11. Once you fall asleep, do you have trouble staying asleep?	□ Y □ N	2
12. Do you find it difficult to manage your weight?	□ Y □ N	1
13. Do you suffer from headaches during the morning or during the night?	□ Y □ N	1
Medical History		
14. Have you been diagnosed with high blood pressure or take medication for it?	□ Y □ N	3
15. Do you suffer from acid reflux?	□ Y □ N	3
16. Do you suffer from heart disease or have you had a stroke?	□ Y □ N	3
17. Have you been diagnosed with a sleep disorder?	□ Y □ N	3
18. Have you stopped using your CPAP device?	□ Y □ N	3
19. Are you wearing your CPAP less than 5 times per week?	□ Y □ N	3
Please add all the questions you answered with YES and enter the total here →		

Risk Level	Low Risk	Moderate Risk	High Risk	Severe Risk
Range Total	0 -3	4-5	6-7	8 +

Informed Consent

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. I authorize for the doctor and his or her staff to evaluate, diagnose, recommend treatment, provide treatment and use appropriate medication as needed. I understand that using anesthetic agents embodies certain risks, and each treatment has its risks and benefits. I consent to and accept the risks associated with my dental treatment.

Signature: **Date:**

FINANCIAL POLICY

Our mission is to deliver the finest, most comprehensive and cost-effective dental care treatment available. Following diagnosis, the doctor will advise you of our plan for your treatment.

PAYMENT OPTION A: CASH, CHECK OR CREDIT CARD
We offer a 5% courtesy accounting adjustment to patients who pay for their treatment in full in cash, check or credit card prior to start of treatment.

PAYMENT OPTION B: FINANCING
Arrangements can be made with a financing company that can assist you in financing your dental work on approved credit. Convenient monthly payment plans allow you to pay over time with no annual fees or pre-payment penalties. No interest financing options are also available.

NOTE FOR PATIENTS WITH DENTAL INSURANCE
Whether you choose Option A or Option B, the total cost of your treatment is due at the start of treatment, this includes services that may be covered by your insurance company. As a courtesy, we will assist you in maximizing your insurance benefits and in receiving your insurance reimbursement. Additional information pertaining to dental insurance is available on Impression Dental Care's Insurance Authorization Form.

NOTE FOR ALL PATIENTS
A 25% deposit will be required at the time of appointment scheduling to reserve 1 or more hour(s) of the doctor's time. A fee of $25 will be charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice. A fee of $45 will be charged for each returned check. Personal checks in the amount of $500 or more must be paid 10 business days prior to start of treatment. If circumstance requires you to discontinue care before treatment is complete, your refund will be determined upon review of your case.

I understand and agree to Impression Dental Care's Financial Policy.

PATIENT, PARENT OR GUARDIAN SIGNATURE _____ DATE _____

PATIENT, PARENT OR GUARDIAN SIGNATURE _____ DATE _____

Credit Card Authorization

□ VISA □ MASTERCARD □ DISCOVER □ AMEX

ACCOUNT NUMBER	EXPIRATION DATE	SECURITY CODE

CARD HOLDER NAME

CARD HOLDER'S ADDRESS	CITY	STATE	ZIP CODE

I authorize **Impression Dental Care** to charge my credit card or debit card for any cancelation fee or returned check fee due on my credit card **immediately upon occurrence per policy** and/or for any balance still owing on my account **45** days from the date of service. I understand that I am responsible for any balance due for services my family or I have received regardless of insurance benefits and/or estimate.

CARD HOLDER'S SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Our office is permitted by federal privacy laws to make uses and disclosures of health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines that they will need to consult with another specialist in the area. The physician will share the information with such specialist and obtain the specialist's input.

Examples of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical car given we will provide information to them about you and the care given.

Examples of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we obtain maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital—we are not required to grant request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital.
- Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request to the office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to the office/hospital. We may deny your request of you ask us to amend information that:
    - Was bit created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not a part of the health information kept by or for the office/hospital;
    - Is not a part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternatives means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your health.
- Revoke authorizations that you made preciously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken. If you want to exercise any of the above rights, please contact the Privacy Officer at the end of this notice, in person or in writing, during regular business hours. The privacy officer will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

Our office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practice and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information of File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Privacy Officer at the practice. You may also file a complaint by mailing in or emailing it to the Secretary of Health and Human Services, whose street address and email address is Office for Civil Rights-U.S. Department of Health and Human Services-200 Independence Avenue S.W. – Room 509F, HHH Building – Washington, D.C. 20201

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protect health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or death.

Research

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

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your protected information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your protected information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation

Public Health

- As Authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse and Neglect

- We may disclose your protect health information to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct and evaluation relating to medical surveillance of the work place or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correction Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your protect health information to appropriate health oversight agency or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as Armed forces personnel, for national security purposes, or to the public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information 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 release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.
- We would like the opportunity to keep you informed of the services offered by all providers of Impression Dental Care and Impression Dental Care.
- You agree to allow us to provide you information on an ongoing basis about all of the services from Impression Dental Care and Impression Dental Care.
- Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services beyond those offered by the Breath Well Center's and Impression Dental Care's providers without obtaining additional consent from you.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of the both practice and the patient.

You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal polices to conform to your request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, do herby consent and acknowledge my agreement to the terms set forth in the NOTICE OF PRIVACY PRACTICES and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

HIPAA INFORMATION & CONSENT

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available for your review in the laminated pages that accompany your registration forms, or by request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with offices services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

We have adopted the following policies:

1. All the staff members are held to the highest levels of confidentiality, and are allowed to access your patient information only to the extent necessary to provide for your care
2. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI and other documents or information.
3. It is policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
5. You understand and agree to inspections of the office and review documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
7. We would like the opportunity to keep you informed of the services offered by all of the Impression Dental Care's providers, including Impression Dental Care. You agree to allow us to provide you information on an ongoing basis about all of the Impression Dental Care's and Impression Dental Care's providers and services. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services beyond those offered by the Impression Dental Care's and Impression Dental Care's providers without obtaining additional consent from you.
8. We agree to provide patients with access to their records in accordance with state and federal laws.
9. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
10. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal polices to conform to your request.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA INFORMATION & CONSENT

I, _____, do herby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION & CONSENT and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE

INSURANCE AUTHORIZATION FORM

Primary Insurance Information

NAME OF INSURED	RELATIONSHIP TO PATIENT □ Self □ Spouse □ Child □ Other		
SOCIAL SECURITY	BIRTH DATE	EFFECTIVE DATE	
EMPLOYER			
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
INSURANCE COMPANY	GROUP #	PHONE #	
INSURANCE ADDRESS	CITY	STATE	ZIP CODE

Secondary Insurance Information

NAME OF INSURED	RELATIONSHIP TO PATIENT □ Self □ Spouse □ Child □ Other		
SOCIAL SECURITY	BIRTH DATE	EFFECTIVE DATE	
EMPLOYER			
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
INSURANCE COMPANY	GROUP #	PHONE #	
INSURANCE ADDRESS	CITY	STATE	ZIP CODE

Dental Insurance Policy

Although we are not an in-network provider with your Insurance Company we are happy to work with your carrier to maximize your benefits. The estimated insurance portion of the treatment will be billed to your insurance company. If the Insurance Company sends the check to us and the received amount created a positive balance on your account, we will apply the credit to your future treatment or give you a refund. It the Insurance Company sends the check directly to you and you still have a balance on your account, please send us the check within 14 days.

If further balance remains after the insurance payment has been applied of if the insurance company denies the claim, the balance will be due immediately. If a payment is not received within 45 days from the date of treatment, the remainder of the balance will be charged to your credit card.

I hereby authorize and request my Insurance Company to pay directly to Impression Dental Care in the amount due on my claim for services rendered to me or my dependent. I also understand and agree to Impression Dental Care's Financial and Dental Insurance Policy.

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PATIENT, PARENT OR GUARDIAN SIGNATURE DATE