

PATIENT REGISTRATION



PATIENT INFORMATION

This appointment is for: ☐ Self ☐ Dependent ☐ Other

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
First Last M.I.

Preferred Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: Male / Female Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Name of person responsible for this account: \_\_\_\_\_

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who should we contact? \_\_\_\_\_  
Contact name

Relationship to patient

Contact phone: ☐ Home ☐ Work ☐ Cell

INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes ☐ No

**If yes, please understand that this is an agreement between you and your employer/insurance company.  
As the insured participant, it is your responsibility to be aware of your policy's benefits and limitations.**

Policy Holder's Name: \_\_\_\_\_  
First Last M.I.

Date of Birth SSN

Name of Insurance Company: \_\_\_\_\_ Contact #: \_\_\_\_\_

Group ID: \_\_\_\_\_ Insurance ID: \_\_\_\_\_

Name of Employer Insurance is through: \_\_\_\_\_

Assignment of Benefits: I hereby authorize insurance payments directly to Southeastern Dental Center. In some cases your insurance company will not allow you to assign benefits to us. This means the insurance company will only send the payment to you. In this case, you are responsible for the total fee at the time of treatment.

SIGNATURE DATE

# MEDICAL HISTORY FORM



Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 for any disease or condition? ☐ 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, vitamins or supplements? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Women: (Check any that apply)

☐ Are you Pregnant/Trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

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 change in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_

DATE \_\_\_\_\_

## AUTHORIZATION TO DISCUSS DENTAL INFORMATION



Patient's Name: \_\_\_\_\_

There may be occasions when you want to give another person the ability to discuss your care at Southeastern Dental Center (appointments, billing, prescriptions, treatment, etc.). Examples include spouse, parent (if you are over 18), another family member, adult child, nursing home staff, care provider, etc. This authorization will allow discussion only. It does not authorize the release of dental records, unless referring you to a specialist. I give permission for Southeastern Dental Center to share my dental information verbally or via email to the following person(s):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

I would prefer to be contacted for automated notifications regarding appointments via **(please check all that apply)**:

☐ Text: \_\_\_\_\_ ☐ Email: \_\_\_\_\_ ☐ Phone: \_\_\_\_\_

There may be occasions when Southeastern Dental Center needs to contact you to discuss your care. I give permission to contact me by phone at **(please check all that apply)**:

☐ Cell: \_\_\_\_\_ ☐ Home: \_\_\_\_\_ ☐ Work: \_\_\_\_\_

I give permission for Southeastern Dental Center to leave messages regarding appointments, treatment, etc., and to release verbal information as described above. Messages may be left on my phone at **(please check all that apply)**:

☐ Cell: \_\_\_\_\_ ☐ Home: \_\_\_\_\_ ☐ Work: \_\_\_\_\_

## AUTHORIZATION TO PAY SOUTHEASTERN DENTAL CENTER

I understand that I will be financially responsible to Southeastern Dental Center for any charges. It is the objective of this office to provide our patients with the best available care and facilities at a reasonable cost. In an effort to eliminate the expense of billing and collection, we ask that you pay for these services as they are rendered. A service charge of 1.5% will be added to your account over 90 days past due, unless an agreement was discussed prior to treatment with Southeastern Dental Center. If you have insurance, please understand that this is an agreement between you and your employer/insurance company. Our bill for services is an agreement between you and us. If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our front office. This will avoid misunderstandings and enable you to keep your account in good standing.

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (Please check ONLY 1 box)

☐ The undersigned hereby acknowledges being offered Southeastern Dental Center's Notice of Privacy Practices and declined a copy.

OR

☐ The undersigned hereby acknowledges receipt of Southeastern Dental Center's Notice of Privacy Practices and received a copy.

## AUTHORIZATION FOR ELECTRONIC (E-MAIL) COMMUNICATION

☐ I agree and consent to receive electronic communication sent to me by Southeastern Dental Center.

E-Mail Address: \_\_\_\_\_

☐ I do not consent to electronic communication to and from Southeastern Dental Center.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If other than yourself, RELATIONSHIP TO PATIENT (Parent, Guardian, Spouse, etc.): \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES (1/2)



### **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.**

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/28/2018, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.** We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.** We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.** We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.** We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.



## NOTICE OF PRIVACY PRACTICES (2/2)



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

**Coroners, Medical Examiners, and Funeral Directors.** We may release your PHI 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 disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

### OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.** You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach.** You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

### 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 if 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.

Our Privacy Official: Southeastern Dental Center  
Telephone: 605-335-8030 Fax: 605-335-0984  
Address: 2851 East Jackson Street Sioux Falls, SD 57108  
E-mail: info@sedentalcenter.com

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