## 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:_____
☐ Responsible Party is also Policy Holder for patient ☐Primary Ins. Holder ☐Secondary Ins.

**Patient Information:**

Address:_____ Address 2:_____
City, State, Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Birth Date:____/____/____ Age:_____ Soc. Sec:_____
Driver's License:_____ Email Address:_____

**Insurance Information:**

**Primary Insurance**
Name of Insured:_____
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Soc. Sec:_____ Insured Birth Date:____/____/____
Employer:_____
Insurance Company:_____
Group Number:_____ Policy Number:_____

**Secondary Insurance**
Name of Insured:_____
Relationship to Insured: ☐Self ☐Spouse ☐Child ☐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.

| | Yes | No | |
|---|---|---|---|
| Are you under a physician's care now? | ☐ | ☐ | If yes, Physician's name: _____ |
| Have you ever been hospitalized or had a major operation? | ☐ | ☐ | Please list: _____ |
| Are you taking any medications, pills, or drugs? | ☐ | ☐ | If yes, please list in the section below. |
| Are you on a special diet? | ☐ | ☐ | If yes, Please explain:_____ |
| Do you use tobacco? | ☐ | ☐ | If yes, what kind? _____ |
| Do you use controlled substances? | ☐ | ☐ | |
| Do you snore? | ☐ | ☐ | If yes, how much?_____ |
| Have you ever been diagnosed with obstructed sleep apnea? | ☐ | ☐ | How long ago?_____ |
| Have you ever been told to wear a CPAP, but can't? | ☐ | ☐ | If yes, why?_____ |

If you answered yes to any of the above questions about sleep, please ask us for more information.

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:

| | Y | N | | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | ☐ | ☐ |
| | | | Heart Pace Maker | ☐ | ☐ | Radiation Treatments | ☐ | ☐ | | | |
| | | | Heart Trouble/Disease | ☐ | ☐ | | | | | | |
| | | | | | | | | | | | |

Have you ever had any serious illness not listed above? Please explain:

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

_____

_____

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. _____ (Pt. Initials)
2. **Extractions and Surgery**
   I understand that all dental extractions or surgeries carry risks. If surgery is needed those risks will be explained to me.
   _____ (Pt. Initials)
3. **Fee for Additional or Specialty Care**
   I understand that I may require treatment beyond what was planned. Such as when there appears to be more damage than shown on the x-ray, etc. Also, I may be referred to a specialist for additional care. I agree to be financially responsible for the additional or specialty care. _____ (Pt. Initials)
4. **Broken Appointments**
   All cancellations must be made 24 hours prior to appointment or are otherwise subject to a broken appointment fee. If I am more than 15 minutes late for my appointment, I will either take the time remaining for my appointment; or if there is not enough time remaining to perform the service scheduled, I must be rescheduled and pay a broken appointment fee of $40 per hour of missed appointment (Ex: One hour = $40, 2 hours = $80). This fee applies to any appointment that is not cancelled 24 hours prior and must be paid before I can be placed on the schedule again. _____ (Pt. Initials)
5. **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. _____ (Pt. Initials)
6. **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. _____ (Pt. Initials)
7. **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.
   _____ (Pt. Initials)
8. **Limitations of Insurance Coverage**
   Insurances may not cover every procedure that we recommend. Some examples include: Nitrous Oxide, temporary dentures, oral or conscious IV Sedation. 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 deductable. 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. _____ (Pt. Initials)
9. **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.
   _____ (Pt. Initials)
10. **My photo is required and is part of my chart; I agree to allow this photo.**
    _____ (Pt. Initials)

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

Patient Signature_____ Date____/____/____

Witness_____

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.

_____ (Pt. Initials)

## 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.

_____ (Pt. Initials)

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.

_____ (Pt. Initials)

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.)

_____ (Pt. Initials)

- *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.

_____ (Pt. Initials)

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.

_____ (Pt. Initials)

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.

_____ (Pt. Initials)

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

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

_____ (Pt. Initials)

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