EAGLEVIEW DENTAL

464 Water Street
Prairie du Sac, WI 53578
eagleviewdental.net

info@eagleviewdental.net
(608) 643-3855

REGISTRATION

Age: _____ **Date**: _____

Patient Name: _____ _____ _____
Last First MI

Date of Birth: _____ ☐ **Male** ☐ **Female**

How do you wish to be addressed _____

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor ☐

Residence - Street _____

City _____ State _____ Zip _____

Phone (H) _____

Phone (C) _____

Phone (W) _____

Email _____

Patient Employed By _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

SS# or Drivers License # _____

Method of Payment: Insurance ☐ Cash ☐ Credit Card ☐

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Someone to notify in case of emergency, not living with you _____

_____

DENTAL INSURANCE

Employee Name _____

Date of Birth _____

Relationship to patient _____

Employer Name _____

Name of Insurance Co. _____

Telephone _____

Group No. _____

Member ID No. _____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and heath care operations that are related to treatment or payment.

I consent to disclosure of my records (of my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.
I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.
I attest to the accuracy of the information on this page.
PATIENTS OR GUARDIANS SIGNATURE

_____

Date _____

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MEDICAL & DENTAL HISTORY FORM

DOB: _____

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

Your Primary Care Physician's name, address, and phone number:

_____

Please mark any of the following to indicate YES in response to the question:

- □ Have you ever had complications following dental treatment?
- □ Are you currently under the care of a physician due to a specific condition?
- □ Have you been hospitalized within the last 5 years due to a surgery or illness?
- □ Are you currently taking any prescription or non-prescription medications?
- □ Do you use tobacco (smoking or chewing)?
- □ Do you require the use of corrective lenses (contacts or glasses)?
- □ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

MEDICATIONS

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If YES, when is the due date? _____

Please indicate if you have experienced any of the following:

- □ Acid Reflux
- □ Anemia
- □ Arthritis
- □ Arythmia
- □ Asthma
- □ Cancer
  - □ Radiation or Chemo
- □ Diabetes
- □ Dizzy/Fainting Spells
- □ Emotional Disorder
- □ Epilepsy
- □ Excessive Bleeding
- □ Head Injury
- □ Heart Disease
- □ Hemophilia
- □ Hepatitis
- □ Herpes
- □ High Blood Pressure
- □ HIV
- □ Joint Replacement
- □ No Epinephrine
- □ Pacemaker
- □ Premedicate
- □ Respiratory Problems
- □ Sinus Problems
- □ Stroke
- □ TB
- □ Thyroid Problem
- □ Ulcers
- □ Amoxicillin Allergy
- □ Aspirin Allergy
- □ Clindamycin Allergy
- □ Codeine Allergy
- □ Fluoride Allergy
- □ Latex Allergy
- □ Lidocaine Allergy
- □ Nickel Allergy
- □ Penicillin Allergy
- □ Seasonal Allergies
- □ Sulfa Allergy

(over)

Do you have any other health issues or allergies?

_____

_____

What is the reason for your dental visit today?

_____

When was your last visit to the dentist (if to a different office)?

_____

What was done on your last dental visit (if to a different office)?

_____

Prior Dentist's name, address, and phone number:

_____

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate YES in response to the question:

□ Do your gums bleed when you brush or floss?
□ Do your teeth experience sensitivity to cold or hot temperatures?
□ Are any of your teeth currently causing you pain?
□ Do you grind your teeth (either consciously or during sleep)?
□ Are any of your teeth loose, or are you concerned about any teeth loosening?
□ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

□ **To the best of my knowledge, all of the proceeding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to providing you with the best dental care possible. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. **Payment for service is always due at the time services are rendered.** We accept cash, check, Mastercard, Visa, Discover and Care Credit. Patients with NO insurance will receive a **5% discount**.

2. Your insurance is a contract between YOU, YOUR EMPLOYER, and the INSURANCE COMPANY. ALL CHARGES ARE YOUR RESPONSIBILITY from the date the services are rendered. Although we may estimate what your insurance company may pay, it is the insurance company that makes the FINAL determination of your eligibility and liability.

3. Regarding insurance plans with which we participate, all co-pays and deductibles are due at the time treatment is rendered.

4. For any work **over $1,000.00** we require that a credit card be kept on file with us with a payment arrangement in place.

5. All accounts must be paid within 30 days, unless definitive financial arrangements have been made. If insurance is involved and account is not paid in 90 days, a FINANCE CHARGE of **1.5%** per month will be imposed. If you have a balance on your account, we will send you a monthly statement which will show the previous balance, any new charges, finance charges (if applied) and any payments or credits applied to the account within the month.

6. If you account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay **ALL** the collection costs which are incurred. If we have to refer collection of an account to an attorney, you agree to pay all legal fees we incur plus all court costs. You understand that if this account is submitted to an attorney or collection agency there is a possibility that the treatment you received at our office will be a matter of public record.

7. In cases of DIVORCE or SEPARATION, the party responsible for the account PRIOR to the divorce or separation remains responsible for the account. The parent authorizing treatment for a child will be the parent responsible for those subsequent charges and/or getting the other parent to pay treatment costs if court ordered.

8. We reserve the right to charge the appropriate fee for any checks that are returned from the bank.

9. We reserve the right to charge a **$50.00** fee for appointments canceled or failed with less than a 24 hour notice to help cover our costs.

AUTHORIZATION

I authorize my insurance company to pay all benefits directly to Eagleview Dental. I understand that my dental insurance may pay less than the actual bill for service. I agree to be responsible for payment of all services to me and my dependents.

I have read the Financial Policy of Eagleview Dental. I understand and agree to this policy.

SIGNATURE: _____ DATE: _____

Print Name: _____

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NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a Notice of Privacy Practices from Eagleview Dental Office.

SIGNATURE: _____ DATE: _____

If patient is under 18 or patient has a guardian/personal representative, complete the following:

Patient's Name: _____

Relationship to Individual: _____

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EAGLEVIEW DENTAL OFFICE

Notice of Privacy Practices

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 03/11/2019 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 in formation 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.

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.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

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.

YOUR HEALTH INFORMATION RIGHTS

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 (email).

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: Dr. Myles D Teteak and Dr. Brieanne M LaBerge

Telephone: 608-643-3855 Fax: 608-643-6295

Address: 464 Water Street, PO Box 126, Prairie Du Sac, WI 53578

Email: info@eagleviewdental.net