

NEW PATIENT INFORMATION

Patient's Name:	M.I.	Preferred Name	Date of Birth:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Whom may we thank for referring you to our office?

Best way to confirm your appointments (Circle One): Text Email Call

Cell Phone #:	Email Address:	Home Phone #:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you have dental insurance? (Circle One): YES NO

Primary Dental Insurance

Policy Holder's Name:	Policy Holder's SS#	Policy Holder's Date of Birth:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Policy Holder's Employer:	Relationship to Patient
<input type="text"/>	<input type="text"/>

Insurance Company Name:	Group #:	ID#:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Insurance Company Address:	City, State, Zip	Ins. Company Phone #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Secondary Dental Insurance

Policy Holder's Name:	Policy Holder's SS#	Policy Holder's Date of Birth:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Policy Holder's Employer:	Relationship to Patient
<input type="text"/>	<input type="text"/>

Insurance Company Name:	Group #:	ID#:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Insurance Company Address:	City, State, Zip	Ins. Company Phone #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Previous Dentist's Name:	Date of Last Visit:
<input type="text"/>	<input type="text"/>

Previous/Current Orthodontist's Name:	Date of Last Visit:
<input type="text"/>	<input type="text"/>

If your wisdom teeth have been extracted, name of Oral Surgeon:	Date/Year:
<input type="text"/>	<input type="text"/>

Do you have any dental concerns? If yes, please explain.

What, if anything, would you change about your smile?

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. _____
Signature of Patient or Guardian

PAYMENT IS DUE AT TIME OF SERVICE

I understand that I am responsible for payment at time services are rendered and am also responsible for paying any co-payment and deductible that my insurance does not cover. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.75% on the balance then unpaid and owed will be assessed each month. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Patient or Guardian (if under age 18) **Date**

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

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City State Zip:

Email:

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Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

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Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

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Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

--	--	--	--

Physician Name:

Physician Phone:

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Pharmacy:

Pharmacy Phone:

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For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Please answer the following:

Y N

Are you taking Birth Control Pills?

Are you pregnant?

If Yes, # of weeks

Are you nursing?

Y N

Do you smoke or use tobacco?

Height:

For Office Use Only

BP Heart Rate:

Weight:

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Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

Emergency Contact: _____ Name _____ Relationship _____ Phone Number

Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)



CONSENT FOR RELEASE OF INFORMATION

I authorize Postle Dental Group to disclose my information to a third party, such as a parent, spouse, significant other, etc., as I designate below. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule.

I authorize:

Name:	Date of Birth:	Relationship to Patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

To receive information on the following: Please check all that apply

- Information related to my dental/medical treatment
- Information related to payment of my dental/medical treatment and/or insurance claims

- I do not give authorization for my information to be disclosed

Print Patient's Name

Patient's Date of Birth

Signature of Patient (Guardian or Medical Power of Attorney)

Date Signed

POSTLE DENTAL GROUP

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 9/23/2013, 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 of 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 law.

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, discover 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 and 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 requirement 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.

Alternative Communications. You have the right to request that we have 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 website or by 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:	Katie Sutermaster
Telephone:	614.850.0446
Fax:	614.850.0449
Address:	3734 Ridge Mill Drive Hilliard, Ohio 43026
Email:	katie@postledental.com