Bailey Family Dental

(317)272-9300)

Patient Information

PATIENT NAME:_____Preferred Name_____

Gender: Male____Female____ Family Status: Married___Single___Widowed___Child___

Birth Date:_____ E-Mail Address_____

Phone #_____ Work#_____Cell Phone#_____

Address_____

City_____State_____ Zip_____

SOCIAL SECURITY #_____Employed By_____

(If Child; RESPONSIBLE PARTY'S NAME_____)

ADDRESS OF RESPONSIBLE PARTY_____CITY_____

STATE_____ZIP CODE_____Birth Date of Responsible party_____

SOCIAL SECURITY # OF SPOUSE_____EMPLOYED BY_____

In Case of Emergency Notify_____

Who Will Pay for This Account_____

Whom may we thank for referring you to our practice?_____

***I authorize the Dentist and their staff to perform any necessary services needed during diagnosis and treatment.*

Signature:_____Date_____

Insurance Information:

Name of Insurance Company_____Group #_____ _
Name of Policy Holder_____DOB_____ SSN_____
Employed By_____

Secondary Information:

Name of Insurance
Co._____Group#_____
Name of Policy Holder_____DOB_____SSN_____

Dental History

ARE YOU HAVING DISCOMFORT AT THIS TIME? YES____NO____

NATURE OF YOUR DISCOMFORT? _____

DATE OF LAST DENTAL VISIT_____

DATE OF LAST X-RAYS_____

HAVE YOU EVER HAD ANY COMPLICATIONS WITH EXTRACTIONS? _____

DO YOU HAVE BLEEDING GUMS? _____

DO YOU GRIND YOUR TEETH?_____

DO YOU SMOKE? _____

IS THERE ANYTHING ABOUT YOUR SMILE YOU WOULD CHANGE? _____

MEDICAL HISTORY

PHYSICIANS NAME_____TELEPHONE_____

DATE OF LAST PHYSICAL_____

ANY RECENT SURGERIES_____

CURRENT MEDICATIONS_____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING?

___HEART PROBLEMS
___HIGH BLOOD PRESSURE
___LOW BLOOD PRESSURE
___CIRCULATORY PROBLEMS
___ NERVOUS PROBLEMS
___RADIATION TREATMENTS
___EXCESSIVE BLEEDING
___HIV
___JOINT REPLACEMENT
___ANEMIA
___ASTHMA
___ARTHRITIS

___HEPATITIS
___SCARLET FEVER
___SINUS PROBLEMS
___STROKE
___TYPHOID FEVER
___TONSILLITIS
___TUBERCULOSIS
___ULCER
___HEART MURMUR
___HERBAL MEDICINES
___PREGNANT
___DIABETES
___OTHER_____

****ARE YOU ALLERGIC TO:**

___PENICILLIN
___ANESTHETICS
___CODEINE
___SULFA DRUGS
___PAIN MEDICATION_____
___ASPIRIN
___KEFLEX
___IODINE
___ERYTHROMYCIN

___LATEX

NOTICE OF PRIVACY PRACTICES
(DENTAL)

THIS NOTICE SESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996(Hippa) is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for converged entities that misuse personal health information.

As required by "HIPAA" we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your ins. Company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders of information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of January 1, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Dept. of Health & Human Services Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For More information about HIPAA or to file a complaint:
The US Dept. of Health & Human Services
200 Independence Ave., S.W.
Washington DC 20201
(202)-619-0257
Toll Free: 1-877-696-6775

I have read the copy of Acknowledgement of receipt of copy of Privacy Practices.

*Name*_____
*Today's Date*_____