PATIENT REGISTRATION

Date:

Social Security #

Patient Name:

Address:

Suite/Apt:

City:

State: Zip:

Email:

Birthdate Age:

☐ Male ☐ Female

Driver's License#:

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Life Partner

Occupation:

Patient Employer or School:

☐ Full Time Employed ☐ Part Time Employed ☐ Retired ☐ Student Full / Part Time

☐ Not Employed ☐ Not A Student

Spouse's Name:

Spouse's Birthday:

Spouse's Social Security #:

Spouse's Employer:

Financial Information

Account Responsibility:

☐ Self ☐ Other:

Relationship to Patient:

☐ No Insurance

Primary Insurance

Subscriber's Name:

Subscriber's Birthdate:

Subscriber's ID/SSN#:

Insurance Company:

Ins Phone:

Relationship to Patient:

Secondary Insurance

Subscriber's Name:

Subscriber's Birthdate:

Subscriber's ID/SSN#:

Insurance Company:

Ins Phone:

Relationship to Patient:

Whom may we THANK for referring you?

_____

PHONE INFORMATION

Home: Work: Cellphone:

Spouse's Work: Spouse's Cell:

Best time to reach you:

IN CASE OF EMERGENCY, CONTACT: ***(Someone other than your spouse)***

Name Relationship

Home Work Cell

HIPAA RELEASE AND CONSENT:

By signing below, I acknowledge that I have reviewed a copy of Stan Scalf DMD's Notice of Privacy Policies. I understand Stan Scalf DMD may use my health care information and may disclose such information for treatment, payment, and other health care operations.

INSURANCE ASSIGNMENT

By signing below, I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Stan Scalf DMD all insurance benefits, if any, otherwise payable to me for services rendered. I certify that if it is indicated that there is no insurance present at this time, this would apply if insurance were to be obtained in the future.

_____

Signature of Patient, Guardian, Or Personal Representative **DATE**

_____

Print Name of Patient, Parent, Guardian, or Personal Representative

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE OF STAN SCALF D.M.D., WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including dentists, physicians, RNs, RDAs, etc.);
- All areas of the Practice (front desk, administration, billing, collection, clinical, etc.);
- All employees, staff, and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call dentists/physicians, and so on.

WE ARE REQUIRED BY LAW TO:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that is currently in effect.

PATIENT HEALTH INFORMATION RIGHTS:

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of this Notice of Privacy for Protected Health Information ("notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record-you may exercise this right by delivering the request in writing to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing at our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

Stan Scalf D.M.D. provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT:

If you have questions, would like additional information, or want to report a problem regarding the handling of your medical information, you may contact the Practice's Office Manager. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Practice's Office Manager. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. All Complaints must be submitted in writing. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the Practice. We cannot, and will not, retaliate against you for filing a complaint with the Secretary. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL/DENTAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical/dental information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are **required to retain our records of the care that we provided to you.**

MILITARY AND VETERANS

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

LAW ENFORCEMENT

- We may release medical/dental information if asked to do so by law enforcement officials.
- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

HEALTH OVERSIGHT

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities. **EXAMPLE**: Audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS

We may disclose your medical/Dental information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

OTHER RESPONSIBILITIES

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice'
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

EMERGENCY SITUATIONS

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or another person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency situation.

FOOD AND DRUG ADMINISTRATION (FDA)

As required by law, we may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

PUBLIC HEALTH

We may disclose medical/dental information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report deaths; To report child abuse or neglect
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease of may be at risk for contraction or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

WORKER'S COMPENSATION

If you are seeking compensation through Workers' Compensation, we may disclose our protected health information to the extent necessary to comply with laws relating to Workers' Compensation.

CORRECTIONAL INSTITUTIONS

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

With your consent, the Practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care of treatment. It also, includes billing documents for those services.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

HOW WE MAY USE AND DISCLOSE MEDICAL/DENTAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical/dental information that we have and share with others. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use of disclosure in a category is either listed or actually in place. The explanation is provided for you general information only.

FOR TREATMENT

We may use medical/dental information about you to provide you with medical/dental treatment or services. We may disclose medical/dental information about you to doctors/dentists, hospitals, nurses, technicians or other Practice personnel who are involved in taking care of you. Different departments of the Practice also may share medical/dental information about you in order to coordinate information such as records, prescriptions, x-rays, etc. We also may disclose medical/dental information about you to people outside the Practice who may be involved in your medical/dental care after you leave the practice, such as your referring dentist, general practitioner, family members or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical/dental decisions, should you become incompetent).

FOR PAYMENT

We may use and disclose medical/dental information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or any other third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

FOR HEATH CARE OPERATIONS

We may use and disclose medical/dental information about you for Practice operations. These uses and disclosures are necessary to run the Practice more efficiently and make sure that all of our patient's receive quality care. We may also combine medical/dental information about many Practice patients to decide what additional services the Practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, students, and other Practice personnel for review and learning purposes. We may also combine the medical/dental information we have with medical/dental information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may also use or disclose information about you for internal or external utilization review and/or quality assurance and improvement, to business associates for purposes of helping us comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process, and the like. We shall endeavor, at all times when business associates are used to advise them of their continued obligation to maintain the privacy of you medical/dental records.

APPOINTMENT AND PATIENT RECALL REMINDERS

We may use and disclose medical/dental information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, or otherwise and my involve leaving a message on an answering machine, or otherwise, which could potentially be received or intercepted by others.

HEALTH-RELATED BENEFITS AND SERVICES

We may use and disclose medical/dental information to tell you about health-related benefits or services that may be of interest to you.

DENTAL HISTORY

PATIENTS NAME:_____

Reason for today's visit:_____

Former Dentist:_____

City/State:_____

Date of last Dental Visit:_____

Date of last Dental X-Rays:_____

PLEASE MARK THE BOX TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Lips or Mouth
- ☐ Burning Sensation on Tongue
- ☐ Chew on One Side of Mouth
- ☐ Cigarette, Pipe, or Cigar Smoking Avg Daily use:_____
- ☐ Clicking or Popping Jaw
- ☐ Interested in Orthodontics (Braces)
- ☐ Dry Mouth
- ☐ Fingernail Biting
- ☐ Food Collection Between Teeth
- ☐ Foreign Objects
- ☐ Grinding Teeth
- ☐ Gums Swollen or Tender
- ☐ Jaw Pain or Tiredness
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Filling
- ☐ Mouth Breathing
- ☐ Mouth Pain, Brushing
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment/Perio Maintenance
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting
- ☐ Sore or Growths in your Mouth
- ☐ Interested in Whitening

How Often do you Floss?_____

How Often do you Brush?_____

Do You Like Your Smile?_____

HEALTH HISTORY

PLEASE MARK THE BOX TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints_____
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding, Abnormally with extractions/surgery
- ☐ Blood Disease
- ☐ Cancer _____
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent/Bloody
- ☐ Diabetes _____
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problem
- ☐ Hepatitis Type_____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Tuberculosis
- ☐ Nervous Problems
- ☐ Anxiety
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Sinus Issues_____
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke, When?_____
- ☐ Swollen Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Mitral Valve Prolapse
- ☐ Tumor/Growth
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss or Gain (unexplained)

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa

OTHER:_____

- ☐ Pregnancy

Due Date:_____

OB/Gyn:_____

_____

Phone:_____

List any medications you are currently taking and the *correlating diagnosis*:

_____

_____

_____

_____

Pharmacy:_____ Address:_____ Phone:_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain any additional medical information from my physician regarding my history in order to provide me with the very best care possible.

Patient Signature_____ Date _____

Parent or Guardian must sign if patient is a minor

Handle Me With Care

- ☐ I gag easily.
- ☐ I feel out of control when I am lying down in the dental chair.
- ☐ I have not been to the dentist for a long time and I feel uncomfortable about what will say or think about my teeth and my dental hygiene.
- ☐ I know I have bad habits that are causing harm to my dental health. I am afraid I might not be able to break them.
- ☐ Pain relief is a top priority to me.
- ☐ I don't like shots, or I've had a bad reaction to shots.
- ☐ Please tell me what I need to know about my mouth so I can make an informed decision.
- ☐ My teeth are very sensitive.
- ☐ I don't like the sound of that tool that makes the picking and scraping noise.
- ☐ I don't like cotton in my mouth.
- ☐ I hate the noise of the drill.
- ☐ I don't like the dental office smells.
- ☐ Please respect my time. I don't want to be left sitting in the reception area.
- ☐ I want to know the cost up front. No money surprises, please.
- ☐ I have difficulty listening and remembering what I hear while sitting in the dental chair.
- ☐ I have health problems and questions that we need to discuss.
- ☐ I don't like being left alone in the treatment area.
- ☐ I have problems with my back.
- ☐ I don't like the chair tipped back too far.
- ☐ I do not like to see dental instruments.
- ☐ I need to talk to you first, without sitting in the dental chair.
- ☐ Other concerns I would like to talk about (Please specify):

_____

_____

_____

_____

FINANCIAL POLICY

Thank you for choosing our practice for your dental care, we are privileged that you are here! Our focus is you, our patient and we take pride in caring for you as we do our own families. The goal of our entire staff is to ensure you have the optimum in dental care and will work to overcome any obstacle that may prevent you from completing any recommended treatment. In order to maintain a positive professional relationship, it is important that we outline our financial policies to provide clarity and to establish a clear understanding of financial responsibilities.

IF YOU HAVE DENTAL INSURANCE- Please Read & INITIAL All Items

_____ Your policy is a contract between you, your employer and/or the insurance company. We are NOT responsible for your policy provisions or limitations on your policy. We strive to gather the most accurate information available from your insurance company, but we are limited to the information given when processing claims. If your insurance company does not pay for services or pays less than estimated by your plan provisions provided, you are responsible to pay the balance in full upon receipt of your monthly statement**. If your coverage changes or *terminates,* you are 100% responsible for the account balance.**

_____ Our office will submit the dental claims on your behalf. However, you are required to pay the ***ESTIMATED*** co-payment at the time of service. We accept cash, checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT as options for your co-payment. ***Any Financing must be confirmed before treatment is started**.

IF YOU DO NOT HAVE DENTAL INSURANCE - Please Read & INITIAL All Items

_____ Balance for services is due at the time of service. Other financial arrangements must be secured prior to starting any dental treatment if payment for services in full is not possible.

_____ We accept cash, checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARE CREDIT as options for your payment. ***Financing must be confirmed before treatment is started**.

ALL PATIENTS Please Read & INITIAL All Items

_____ Our office REQUIRES a 24 hour CANCELLATION NOTICE to be given to our office Staff if you are unable to keep your scheduled appointment. FAILURE to give our office this notice will RESULT in a $50.00 CANCELLATION FEE charged to your account.

_____ If your account is turned over to the Collection Agency of our choice and or legal action is pursued to collect the debt, you will be responsible for all costs associated with the collection of this debt.

TRUTH IN LENDING

EXPLANATION OF INTEREST RATES, INTEREST CHARGES AND FEES INTEREST RATES AND INTEREST CHARGES	
Annual Percentage Rate (APR) for Purchases	**8.00%**
Paying Interest	A finance charge is imposed on those charges not paid in full within 30/60/90/120 days (as shown on the front of your billing statement) of the date you were first billed for the charges. The balance on which any finance charge is computed is determined by totaling the charges not paid within the time period shown on the front of your billing statement and then by multiplying the balance by the periodic rate shown.
Minimum Interest Charge	**If you are charged interest, the charge will be no less than $1.00**

FEES

Late Charge	**$1.00 or 5% of the past due minimum payment, whichever is greater, with a maximum of $5.00**
Non-Sufficient Funds (NSF) Fee	**$25.00 per payment**

YOUR BILLING RIGHTS UNDER THE FAIR CREDIT BILLING ACT

If you think you have been billed incorrectly, or if you need more information about a transaction on your bill, write to us on a separate sheet at First Pacific Corporation, PO Box 3000, Salem, OR 97302. We must hear from you no later than 60 days after we have sent you the first bill on which the error or problem appeared. You may telephone us at 1-800-574-7064, but doing so will not preserve your rights. In your letter, please include the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are not sure about.

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

- We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct or explain why we believe the error was correct.
- After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount in question, including finance charges and we can apply any amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.
- If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.
- If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill and we must tell you the name of anyone we reported you to. When the matter is finally settled between us, we must tell anyone we report you to that it has been settled.
- If we don't follow these rules, we can't collect the first $50.00 of the questioned amount even if your bill was correct.
- Your continued use of this account constitutes your acceptance of the above stated conditions.

I agree to be responsible for all charges for dental services and material not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to any insurance claims.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dental entity, Stan Scalf DMD.

Signature_____ Print Account Name_____Date_____

REQUEST FOR RELEASE OF DENTAL INFORMATION

Patient's name _____
PLEASE ***PRINT*** NAME

Patient's Date of Birth _____

I hereby grant permission to:

_____
Print Name of Previous Dentist

_____
Address of Previous Dentist

To release all information related to my dental history, status, and treatment along with copies of my health record, X-rays, treatment record, and any test results to:

STAN SCALF D.M.D.
402 BOSTON SQUARE
GEORGETOWN, KY 40324
Phone: (502) 863-9340

EMAIL: office@drstanscalfdmd.com

FAX: (833) 790-5103

Signature_____ Date_____
(If a minor, parent or guardian must sign)