

PATIENT REGISTRATION

ID: Chart ID:
First Name: Last Name: Middle Initial:
Patient Is: Policy Holder Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:
Address: Address 2:
City, State, Zip: Pager:
Home Phone: Work Phone: Ext: Cellular:
Birth Date: Soc Sec: Drivers Lic:
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: Address 2:
City: State / Zip: Pager:
Home Phone: Work Phone: Ext: Cellular:
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed
Birth Date: Age: Soc Sec: Drivers Lic:
E-mail: I would like to receive correspondences via e-mail.

Section 2

Section 3

Employment Status: Full Time Part Time Retired
Student Status: Full Time Part Time
Medicaid ID: Pref. Dentist:
Employer ID: Pref. Pharmacy:
Carrier ID: Pref. Hyg:

Referred By
Previous Dentist
Emergency Contact
Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City, State, Zip: City, State, Zip:
Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other
Insured Soc. Sec: Insured Birth Date:
Employer: Ins. Company:
Address: Address:
Address 2: Address 2:
City, State, Zip: City, State, Zip:
Rem. Benefits: Rem. Deduct:

Bridgeport Smiles
Eaglesoft Medical History (Copy)

Patient Name: _____

Birth Date: _____

Date Created: _____

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.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever had complications from a tooth extraction? (osteonecrosis, severe bleeding, etc)	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____

Women: Are you...

Pregnant/Trying to get pregnant?

Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin
 Metal
 Other

Penicillin
 Latex

Codeine
 Sulfa Drugs

Acrylic
 Local Anesthetics

Do you use controlled substances (narcotics or prescribed pain meds)? Yes No

If yes _____

Other?

If yes _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No
Alzheimer's Disease Yes No
Anaphylaxis Yes No
Anemia Yes No
Angina Yes No
Arthritis/Gout Yes No
Artificial Heart Valve Yes No
Artificial Joint Yes No
Asthma Yes No
Blood Disease Yes No
Blood Transfusion Yes No
Breathing Problems Yes No
Bruise Easily Yes No
Cancer Yes No
Chemotherapy Yes No
Chest Pains Yes No
Cold Sores/Fever Blisters Yes No
Congenital Heart Disorder Yes No
Convulsions Yes No
Yellow Jaundice Yes No

Cortisone Medicine Yes No
Diabetes Yes No
Drug Addiction Yes No
Easily Winded Yes No
Emphysema Yes No
Epilepsy or Seizures Yes No
Excessive Bleeding Yes No
Excessive Thirst Yes No
Fainting Spells/Dizziness Yes No
Frequent Cough Yes No
Frequent Diarrhea Yes No
Frequent Headaches Yes No
Genital Herpes Yes No
Glaucoma Yes No
Hay Fever Yes No
Heart Attack/Failure Yes No
Heart Murmur Yes No
Heart Pacemaker Yes No
Heart Trouble/Disease Yes No
Irritable Bowel Syndrome Yes No

Hemophilia Yes No
Hepatitis A Yes No
Hepatitis B or C Yes No
Herpes Yes No
High Blood Pressure Yes No
High Cholesterol Yes No
Hives or Rash Yes No
Hypoglycemia Yes No
Irregular Heartbeat Yes No
Kidney Problems Yes No
Leukemia Yes No
Liver Disease Yes No
Low Blood Pressure Yes No
Lung Disease Yes No
Mitral Valve Prolapse Yes No
Osteoporosis Yes No
Pain in Jaw Joints Yes No
Parathyroid Disease Yes No
Psychiatric Care Yes No

Radiation Treatments Yes No
Recent Weight Loss Yes No
Renal Dialysis Yes No
Rheumatic Fever Yes No
Rheumatism Yes No
Scarlet Fever Yes No
Shingles Yes No
Sickle Cell Disease Yes No
Sinus Trouble Yes No
Spina Bifida Yes No
Stomach/Intestinal Disease Yes No
Stroke Yes No
Swelling of Limbs Yes No
Thyroid Disease Yes No
Tonsillitis Yes No
Tuberculosis Yes No
Tumors or Growths Yes No
Ulcers Yes No
Venereal Disease Yes No

Have you ever had any serious illness not listed? Yes No

If yes _____

Comments:

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: _____

X

Date: _____

Bridgeport Smiles Notice of Privacy Practices

Last Updated: August 2014

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

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Bridgeport Smiles ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Bridgeport Smile's Privacy Official at: Robert M. Gombert 208 S. LaSalle, Ste. 14140, Chicago, Illinois 60604 (312)223-6194 ext.25

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

IV. Last Revision Date

This Notice was last revised on August 14, 2014.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

Common Uses and Disclosures

1. **Treatment.** We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
2. **Payment.** We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
3. **Health Care Operations.** We may use and disclose health information about you in connection with health care operations necessary to run our practice.
4. **Appointment Reminders.** We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.
5. **Treatment Alternatives and Health-Related Benefits and Services.** We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
6. **Disclosure to Family Members and Friends.** We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object.
7. **Disclosure to Business Associates.** We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

TURN OVER

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES FOR BRIDGEPORT SMILES

Last Updated: August 2014

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Bridgeport Smiles HIPAA Notice of Privacy Practices.

I understand that Bridgeport Smiles HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Bridgeport Smiles revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Bridgeport Smiles HIPAA Notice of Privacy Practices, I may contact Robert M. Gomberg (312) 332-6194 ext.25.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Bridgeport Smiles will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Bridgeport Smiles privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Robert Gomberg, noted above, for assistance.

Patient Signature _____ Date _____

(Or personal representative to patient)

FOR OFFICE USE ONLY

Bridgeport Smiles made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. In spite of these efforts, Bridgeport Smiles was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on _____, 20_____.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____

Date _____ Received By _____

Financial Policy Agreement, Cancellation/No Show Policy, Assignment of Benefits, General Authorizations

Thank you for choosing Bridgeport Smiles as your dental health care provider. We are committed to providing you with the highest quality of dental care, so that you may fully attain optimum oral health. Please read carefully and sign below. You may request a copy.

___(initial here) Payment is due at the time service is provided. Our office accepts cash, personal checks up to \$200, as well as MasterCard, Visa, American Express and Discover. Outside financing is available through Care Credit and other dental credit cards at our office. Ask us for details and an application.

___(initial here) As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you. However it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Any dental office is not a party to that contract.

Cancellation & No Show Policy

___(initial here) Rescheduling must be given 24 hours before the appointment time. You may be rescheduled if you are more than 15 minutes late and you may be charged a \$30 cancellation fee if you do not show for your scheduled appointment or if you cancel within 24 hours of your appointment. If you fail to keep more than 3 appointments without advance notification, you may be restricted to a walk-in or time available basis.

OPTIONAL:

I authorize the following name(s) to have access to the patient's dental information (other than the legal guardian/parent)

NAME: _____ Relationship: _____

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understand and agree to the above terms and conditions.

Patient/Guardian Signature: _____ Date _____