

Welcome to our Dental Practice

DATE: \_\_\_\_\_

Dr., Mr., Mrs., Ms. FULL NAME: \_\_\_\_\_
please print: First Middle Last

ADDRESS: \_\_\_\_\_
Address City State Zip code

TELEPHONE #'s: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_
Home Work ext Mobile / Cellular / Pager

GENDER: \_\_\_ male, \_\_\_ female MARITAL STATUS: single, married, separated, divorced, widowed, other

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_
month day year

EMPLOYMENT STATUS: Full time, Part time, Retired, Not applicable, STUDENT STATUS: Full time, Part time, N/A

EMPLOYER OR SCHOOL NAME: \_\_\_\_\_

ADDRESS OF EMPLOYMENT OR SCHOOL: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_, RELATIONSHIP: \_\_\_\_\_

BILLING ADDRESS: \_\_\_\_\_
(if different than above)

ALTERNATE CONTACT PERSON: \_\_\_\_\_ PHONE #: \_\_\_\_\_

Are you covered by Dental Insurance? Yes, No, If yes, Policyholder's Name: \_\_\_\_\_

What source may we thank for referring you to our practice? \_\_\_\_\_

APPOINTMENT PREFERENCE, if available: Mornings, Afternoons, No preference, \_\_\_\_\_
If an unexpected time opens, might you be available for appointments on SHORT NOTICE? Yes, No, Maybe

If you would like correspondence via email, please list your email address: \_\_\_\_\_

Dental History and Health Information

When was your last dental examination and cleaning? \_\_\_ 6 months ago, \_\_\_ 1 year ago, \_\_\_ 2 years ago, \_\_\_ longer

Reason for your current visit with us: \_\_\_\_\_

Do you have any other dental concerns or interests? \_\_\_\_\_

Is any part of your mouth especially sensitive to pressure, or irritants such as cold, sweets, etc. ? . . . . \_\_\_ Yes \_\_\_ No
If yes, please specify:

Do you have any unhealed injuries, sore spots, or swollen areas in or around your mouth? . . . . . \_\_\_ Yes \_\_\_ No

Do you have pain or clicking when opening or closing your jaw? . . . . . \_\_\_ Yes \_\_\_ No

Are you under the care of a dental specialist (orthodontist, endodontist, periodontist, etc.)? . . . . . \_\_\_ Yes \_\_\_ No
If yes, please specify:

Have you ever had radiation treatments or therapy? . . . . . \_\_\_ Yes \_\_\_ No

Do you frequently have a sore throat? \_\_\_ Yes \_\_\_ No, Have you ever received a blood transfusion? \_\_\_ Yes \_\_\_ No

Have you ever received any donor organs, implants, artificial heart valves/vessels, pacemaker, or joint implants?
\_\_\_ Yes \_\_\_ No, if yes please specify:

Have any wounds healed slowly or presented complications? . . . . . \_\_\_ Yes \_\_\_ No

Medical Physician's Name: \_\_\_\_\_ Phone #(if available) \_\_\_\_\_

Physician's address, or location : \_\_\_\_\_

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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? Yes No If yes, please explain: \_\_\_\_\_
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: \_\_\_\_\_
Have you ever had a serious head or neck injury? Yes No If yes, please explain: \_\_\_\_\_
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: \_\_\_\_\_
Do you take, or have you taken, Phen-Fen or Redux? Yes No \_\_\_\_\_
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No \_\_\_\_\_
Are you on a special diet? Yes No \_\_\_\_\_
Do you use tobacco? Yes No \_\_\_\_\_
Do you use controlled substances? Yes No \_\_\_\_\_
Do you need to pre-medicate? Yes No If yes, please explain: \_\_\_\_\_
Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

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

Table with 12 columns listing various medical conditions (e.g., AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis) and their status (Yes/No).

Have you ever had any serious illness not listed above? Yes No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

**PATIENT CONSENT AND ACCOUNTABILITY**

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 the patient's) health. It is my responsibility to inform the dental office of any changes in medical or health status, or medications.

I hereby authorize Nail Dental L.L.C., Dr. Gary Nail, Dr. Jim Nail, and/or their associates and staff to perform any and all treatment for myself, or the named patient, and consent to such procedures, methods, drugs, and agents as may be indicated in connection with dental care. This consent shall remain in effect until cancelled in writing.

I understand that payment is expected on the day of service. I understand that all fees are my responsibility to pay in full. Nail Dental L.L.C. will accept assignment of dental insurance benefits, if desired, and I understand that any portion of the fee charged that has not been paid by insurance benefit within 60 days of insurance form submission, will be my responsibility to pay in full, at that time. Interest will be charged at a rate of 1.5% per month on all accounts over 90 days past due. I agree to pay interest charges, and all collection fees, legal fees, and court costs to Nail Dental L.L.C., Dr. James Gary Nail, and Dr. James Gregory Nail, pertaining to the collection of my account if delinquent.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Nail Dental L.L.C.

Dental Insurance "Signature on File" Form

Patient Name: \_\_\_\_\_ \*\* Please SIGN in BOTH places below \*\*

PRIMARY DENTAL INSURANCE: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # or Ins. ID #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group or Policy #: \_\_\_\_\_

SECONDARY DENTAL INSURANCE, if any: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # or Ins. ID #: \_\_\_\_\_

Employer: \_\_\_\_\_ Group or Policy #: \_\_\_\_\_

Any other special information you are aware of that will be needed to file your Dental Insurance Claims:

RELEASE OF INFORMATION

I hereby authorize the release of any medical, dental, or other information necessary to process my dental claims. I understand that I am personally responsible for all costs of dental services.

\*\* \_\_\_\_\_ \*\*

Patient's or Authorized Person's Signature

ASSIGNMENT OF BENEFIT

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the dental provider listed for services rendered and listed on my claim form.

\*\* \_\_\_\_\_ \*\*

Insured or Authorized Person's Signature

Nail Dental L.L.C.

Acknowledgement of Receipt of Notice of Privacy Practices

\* You May Refuse to Sign This Acknowledgment \*

I have received a copy, or been given the opportunity to receive a copy, of this office's Notice of Privacy Practices. I understand that I may request a copy of the Nail Dental Notice of Privacy Practices, at any time.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

↓ Space Below For Office Use Only ↓

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) \_\_\_\_\_

# Nail Dental L.L.C.

## 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 March 15, 2016, 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 SEND HEALTH INFORMATION ABOUT YOU

Your protected health information (PHI) includes information relating to your health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. PHI may also include such personal information as a Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information. There is security risk in any type of information transfer. Our practice will always try to send the minimal amount of identifiable information necessary for the task.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email, text, or other electronic forms of communication.

There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

### 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.

**Appointment Reminders.** Appointment reminders are made through phone calls, voicemails, emails, and text messages. We communicate the least amount of information possible, and no sensitive identifiable information is relayed. Opt-out or method preference is available.

**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.** Although we have not, and do not plan to, participate in Fundraising, we may contact you to provide you with information about such 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.

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: You may contact our Front Office Manager, during our normal business hours, for the name and contact information of our current Privacy Official.

Telephone: (417) 881-1212 Fax: (417) 881-7867

Address: Nail Dental L.L.C., 1200 E. Woodhurst Dr., Bldg. M-400, Springfield, MO 65804

**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 at the number or address listed at the end of this Notice.

**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.