Patient Information

Patient Name: ____

Last First Middle Initial Preferred

Gender: Male / Female Family Status: Single/Married/Child/Other

Social Security Number: ____________________Birth Date: ____________

Home Phone: _______________Cell: ____________Work:____________

Address: ____

Street City State Zip Code

Employer: ______________________Address:______________________

How did you hear about us? ______________________________________

Health Information

Date of Last Dental Visit: ______________ Reason for Today's Visit:___________

Have you ever had any of the following? Please check all that apply.

___Aids/HIV ___Allergies ___Anemia ___Arthritis

___Artificial Joints ___Heart Valve ___Asthma ___Blood Disease

___Cancer ___Diabetes ___Epilepsy ___Glaucoma

___Excessive Bleeding ___Fainting/Dizzy ___Hay Fever ___Head Injury

___Heart Disease ___Heart Murmur ___Hepatitis C ___Pacemaker

___High Blood Pressure ___Kidney or Liver Disease ___Stroke

___Currently Pregnant ___Radiation Treatment ___Rheumatism

___Rheumatic Fever ___Respiratory Problems ___Tuberculosis

___Tumors ___Ulcers ___Herpes ___Mitral Valve Prolapse

List any medical allergies: ____

___Penicillin ___Codeine ___Latex

List Medications: ____

____

____

Have you ever had any complications following dental treatment? Yes/No

If yes please explain: ____

Have you been admitted to a hospital or needed emergency care in the last two years? Yes/No

If yes please explain: ____

Are you now under the care of a physician? Yes/No

If yes, please explain: ____

Name of physician: ____

To the best of my knowledge, all of the above answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at my next appointment without fail.

Patient/Guardian Signature: ______________________________ Date:______________

Emergency contact: ______________________________Phone___________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services or any dental services performed without previous financial arrangements must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services finished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare that patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on assumption that our charges will be paid by an insurance company. I understand that the free estimate listed for this dental care can only be extended for a period of six months from the date of the patient examinations. In consideration for the professional services rendered to me or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assigned at the time services are rendered. I further agree that the reasonable value of said services shall be billed unless objected by me in writing within the time for payment thereof, I further agree that any breach at any time or condition shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient or Guardian: ______________________________ Date: ________________

Signature of guarantor of payment: ______________________________ Relationship to patient: ________

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Margaret Nichols, Dr. Lake Garner, Dr. Amanda Jacobs, Dr. Karla Haik, Dr. Will Jones or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by any of the following dentist to make a thorough diagnosis of (name of patient) ______________________________ dental needs.

2. Upon such diagnosis, I authorize Dr. Margaret Nichols, Dr. Lake Garner, Dr. Amanda Jacobs, Dr. Karla Haik, and Dr. Will Jones to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made.

PATIENT____**DATE**____________

WITNESS____**DATE**____________

PARENT OR RESPONSIBLE PARTY____

RELATIONSHIP TO PATIENT____

Vicksburg Family Dental

Acknowledgement of Receipt of Notice of Privacy Practices

~You may refuse to sign this acknowledgement~

I, ________________________________, have received a copy of this office's notice of Privacy Practices.

Please Print Name ____________________________________

Signature ____________________________________

Date ____________________________________

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*
- *Communication barriers prohibited obtaining the acknowledgement*
- *An emergency situation prevented us from obtaining acknowledgment*
- *Other – Please Specify* ____________________________________

Vicksburg Family Dental

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 CAREFULLY; THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices in this Notice while it is in effect. This Notice takes effect 4/14/2003 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. We reserve the right to make the changes in our privacy practice and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to provide treatment plans for you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, revising the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgement, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence of the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstance. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information or inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or locations you request.

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.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 you disagree with a decision we made about access to your health information or in response to a request you have made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or 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.

Contact Office: Vicksburg Family Dental
Phone: (601)636-5321
Address: 3425 Pemberton Sq. Blvd. Vicksburg, MS 39183