BIVONA
FAMILY DENTISTRY

(PLEASE PRINT)

Patient Name: _____

Date of Birth: _____ Date: _____

MEDICAL HISTORY

Do you have or have you had any of the following? PLEASE CHECK IF YES

- ☐ AIDS/HIV POSITIVE
- ☐ ANAPHYLAXIS
- ☐ ANEMIA
- ☐ ARTIFICIAL HEART VALVE
- ☐ ARTIFICIAL JOINT
- ☐ ASTHMA
- ☐ BLOOD PROBLEMS
- ☐ BREATHING PROBLEMS
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ CHEST PAIN/ANGINA
- ☐ CONGENITAL HEART DISORDER
- ☐ DIABETES
- ☐ DRUG ADDICTION
- ☐ EPILEPSY OR SEIZURES
- ☐ FAINTING SPELLS/DIZZINESS
- ☐ HEART ATTACK/FAILURE
- ☐ PACEMAKER
- ☐ HEART DISEASE
- ☐ HEPATITIS A, B OR C
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HYPOGLYCEMIA
- ☐ KIDNEY DIALYSIS
- ☐ KIDNEY PROBLEMS
- ☐ LEUKEMIA
- ☐ LIVER DISEASE
- ☐ LUNG DISEASE
- ☐ OSTEOPOROSIS
- ☐ PAIN IN JAW JOINT
- ☐ RADIATION TXT.
- ☐ RHEUMATISM
- ☐ SHINGLES
- ☐ SICKLE CELL DISEASE
- ☐ SINUS TROUBLE
- ☐ SERIOUS HEAD/NECK INJURY
- ☐ STOMACH PROBLEMS
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ TUMORS/GROWTH
- ☐ ULCERS
- ☐ OTHER MEDICAL CONCERNS:

_____

_____

☐ **HAVE YOU TAKEN FOSAMAX, BONIVA, ACTONOL, XGEVA, or PROLIA?**
IF YES, WHICH ONES? _____

_____

_____

DO YOU WANT NITROUS OXIDE (LAUGHING GAS)? YES____ NO____

ARE YOU TAKING ANY MEDICATIONS?
YES____ NO____

PLEASE LIST ALL MEDICATIONS YOU TAKE:

_____

_____

_____

_____

_____

_____

ARE YOU ALLERGIC TO THE FOLLOWING?

- ☐ PENICILLIN
- ☐ CODEINE
- ☐ LOCAL ANESTHETICS
- ☐ METAL
- ☐ LATEX
- ☐ SULFA DRUGS
- ☐ OTHER

ARE YOU PREGNANT? YES____ NO____
ARE YOU NURSING? YES____ NO____

ARE YOU UNDER THE CARE OF A PHYSICIAN?
YES____ NO____
IF SO, WHY?

_____

_____

_____

PHYSICIAN NAME & PHONE #:

_____

_____

_____

_____

SIGNED _____ **DATE** _____

Patient, Parent or Guardian

PATIENT INFORMATION

DATE _____

Name: _____ Marital Status: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

D.O.B.: _____ Phone (Home): _____ (Cell): _____

(Work:) _____ Place of Employment: _____

Email: _____

SSN: _____ Driver's License: _____

Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

D.O.B.: _____ Phone (Home): _____ (Cell): _____

Place of Employment: _____ SSN: _____

DENTAL INSURANCE INFORMATION (PRIMARY)

Name of Insured: _____ Relationship: _____

Employer: _____ Contract Number: _____

Name & Address of Insurance Company: _____

Group Number: _____ D.O.B. of Insured: _____ SSN: _____

RELEASE SIGNATURE FOR DENTAL BENEFITS:

I hereby authorize payment directly to Bivona Family Dental of the group benefits otherwise payable to me.

Patient: _____ Insured: _____

METHOD OF PAYMENT: Cash, Check, Major Credit Cards, or Care Credit

Payment is due in full at each appointment.

* I understand that there is a $50.00 per hour charge on cancellations without a 4 hour notice. I also understand that treatment

INSURANCE PATIENTS ONLY:

As a courtesy to our patients, we will file your insurance, but you are responsible for all costs. Accounts must be cleared within 30 days!

The parties hereto, whether maker, surely or endorser, waive all rights of exemptions which they have under the Constitution and laws of this state, or any other state, or of the United States and agree to pay all reasonable costs of collection including an attorney's fee, and court costs, and the unpaid balance shall bear a monthly service charge at the rate of 1.5% per month, 18% per annum.

I have read and understand I am responsible for all costs of dental treatments.

Patient's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please enter your name here.

_____

Sign here once forms are printed out.

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because

- ☐ The patient refused to sign
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment
- ☐ We weren't able to communicate with the patient
- ☐ *Other (Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal not state law.

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
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 our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect Jan. 3, 2013 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 practices 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 privacy practices, or for additional copies of the 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 a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and 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, reviewing the competence or qualifications of healthcare professionals, evaluating 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 authorization, you may revoke it in writing at any time. Your revocation will not effect any use of 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 representitive or another person responsible for your care, or your location, your general condition, or death. If you are present then, prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circustances, 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 or 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 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 institutions or law enforcement officials having lawful custody of protected health information of an 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 $1.00 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If your request an alternate format, we will prepare a summary or an explanation of your health information for a fee. 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 disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before Jan. 3, 2013. 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.

ATERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or 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.

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 web site or by electronic mail, you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS: If you want 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 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 make your complaint to us using the information listed at the end of this notice. You may also 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 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 The U.S. Department of Health and Human Services.

CONTACT OFFICER: Susan Kilgore
TELEPHONE: 205-387-8888