Star City Family Dentistry

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

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsilitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain In Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

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

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 _____ DATE _____

PATIENT REGISTRATION FORM

Adult			Child		
Name	Social Security Number		Name	Social Security Number	
Spouse	Social Security Number		Parents Name		
Address			Address		
City	State	Zip	City	State	Zip
Home Phone	Business Phone		Home Phone		
Date of Birth	Age		Date of Birth	Age	

Married	Single	Divorced	Widowed	School

Getting to Know You	Dental Insurance
Patient's Employer	Primary Carrier
Present Position	Subscriber Name
How Long Held	Subscriber Date of Birth
Business Address	Secondary Carrier
Spouse's Employer	Subscriber Name
Present Position	Subscriber Date of Birth
How Long Held	In Case of Emergency
Purpose of Call	Name
Referred by	Phone Number

Account Information	
Who Will Pay This Account	Bank
Address City	State Zip

Financial Policy

I understand that I am responsible for payment for all services rendered. In the event my account becomes delinquent or remains unpaid over 90 days from the date of service, I will be responsible for interest at the rate of 18% from the date of service on the outstanding principal balance. If my account is forwarded to an attorney for collection, I will be responsible for an attorney fee of 35% of the principal balance due at the time the account is turned over.

Signature Date

NOTICE OF PRIVACY PRACTICES – HIPAA & 42 CFR PART 2

This Notice of Privacy Practices ("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.

Protected health information (PHI) includes information that identifies you and relates to your past, present, or future physical or mental health or condition, the healthcare services you receive, or payment for those services.

Some types of health information, including records related to Substance Use Disorder (SUD), receive additional protections under federal law, including regulations found at 42 CFR Part 2, in addition to HIPAA. These enhanced protections are explained later in this Notice.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that your health information is personal and confidential. We are committed to protecting the privacy and security of your protected health information (PHI). We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice
- Notify you if a breach occurs that may have compromised the privacy or security of your information

HOW WE MAY USE AND DISCLOSE YOUR PHI

Treatment – We may use and disclose your PHI to provide, coordinate, or manage your dental care and related services.

Payment – We may use and disclose your PHI to obtain payment for services provided to you.

Healthcare Operations – We may use and disclose your PHI for practice operations, including quality assessment, staff training, legal compliance, auditing, and business planning.

Appointment Reminders – We may use or disclose your PHI to contact you about appointments, reminders, or treatment alternatives.

Required by Law – We may use or disclose your PHI when required by federal, state, or local law.

Emergencies – We may use or disclose your PHI in emergency situations as necessary to protect your health or safety.

Public Health Activities – We may disclose PHI for public health purposes, including disease prevention and reporting.

Military, National Security, and Protective Services – We may disclose PHI as required for military activities, national security, and protective services.

Research – We may use or disclose your PHI for research purposes when approved by law and with appropriate safeguards.

Legal Proceedings – We may only disclose PHI in response to a valid court order or other lawful process or by your written consent.

Marketing – We will not use your PHI for marketing purposes without your written authorization.

Personal Representatives – We may only disclose your PHI to a personal representative authorized by you in writing.

Business Associates – We may share your PHI with business associates who perform services on our behalf. These business associates are required by law to safeguard your information.

Workers' Compensation – We may disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS

Some health information is considered especially sensitive and receives enhanced protection under federal law, including information related to Substance Use Disorder (SUD).

Even if this practice is not a substance use treatment provider, these protections may apply if we receive, maintain, or transmit SUD-related information as part of your health record.

How SUD Information May Be Used

SUD-related records may be used and disclosed for treatment, payment, and healthcare operations, as permitted by law, unless you request additional restrictions.

Prohibition on Legal Use

SUD-related records may not be used against you in criminal, civil, or administrative proceedings without your written consent or a specific court order.

Redisclosure Limitations

SUD-related information may not be redisclosed unless permitted by law. Additional restrictions may apply beyond standard HIPAA rules.

Fundraising Restrictions

Your SUD-related information will not be used for fundraising purposes without your consent. You have the right to opt out of fundraising communications.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- **Access** – Obtain a copy of your PHI
- **Amendment** – Request corrections to your PHI
- **Accounting of Disclosures** – Receive a list of certain disclosures of your PHI
- **Restrictions** – Request limitations on how we use or disclose your PHI
- **Confidential Communications** – Request communications in a specific manner/location
- **Fundraising Opt-Out** – Opt out of fundraising communications
- **Breach Notification** – Be notified of breaches of unsecured PHI
- **Complaints** – File a complaint with the Office for Civil Rights without retaliation

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. Any changes will apply to all PHI we maintain. The updated Notice will be available upon request, in our office, and on our website.

Star City Family Dentistry, Inc.

Appointment Policies

An appointment on our schedule is a bond of trust that we will be here to serve you, and you will be present for treatment. Star City Family Dentistry, Inc. does not double book appointments. This allows us to give you our full attention at your appointment. Our office policy is firm in this regard, and we will not tolerate frequent cancellations, constant short-notice changes or tardiness. We must have mutual respect for each other's time. We make every effort to be on time for our patients and ask that you extend the same courtesy to us. We will not be able to treat patients who have a history of missed/cancelled appointments or are late without valid reasons.

ALL minors under the age of 18 are REQUIRED to have a parent/legal guardian (in cases of children of divorced/separated parents) present during the appointment, unless an authorization for minor child accompany form has been signed by parent or legal guardian. If an authorization for minor child accompany form is being utilized the person being authorized to bring the child must be 18 or older.

As a courtesy, our staff attempts to confirm appointments two days before the appointments scheduled date and time. However, it is ultimately your responsibility to keep your appointment and be on time, even if we have not been able to contact you. We also ask that you arrive 10 minutes prior to your appointment time in order to update any personal information, insurance changes and to pay any patient portion of treatment that may be due at that time. The appointment time is the actual time that you should be seated and prepared for treatment.

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give 24 hour notice to reschedule or cancel any appointment. This will allow us time to offer the newly available appointment slot to other patients. While we understand that unforeseen circumstances occur, we just ask that you please respect the time that we have reserved just for you.

Star City Family Dentistry, Inc. allows for one failed appointment before a $75.00 reschedule fee is required. Broken appointment fees are applied to each individual appointment that is failed. For example if you have a family with multiple appointments failed, each family member will incur a broken appointment fee.

If you arrive 10 minutes late for a hygiene appointment you will be required to reschedule that appointment. Every subsequent time that you arrive 10 minutes late you will be required to reschedule the appointment and pay a $75.00 reschedule fee.

If you arrive 10 minutes late for an appointment with Dr. Bradley, treatment may be altered to perform another treatment in the remaining time of the appointment or you may be asked to reschedule the appointment. Every subsequent time that you arrive 10 minutes late and an alternate treatment cannot be performed, in the time remaining, you will be required to pay a $75.00 reschedule fee.

If you call the office stating that you are on your way, and it is already your appointment time or into your appointment time, you will be asked to reschedule the appointment. You can do this while you are on the phone, or you can call back to reschedule. If you have failed previously or have cancelled with less than 24 hour notice previously, you will be charged the $75.00 reschedule fee.

For established patients, if three failed appointments occur, our office reserves the right to NOT schedule any subsequent appointments, and you will be dismissed from the dental practice.

New patients will NOT be accepted into the dental practice, if they fail to show or cancel without proper 24 hour notice for the initial new patient appointment.

All NEW PATIENTS must confirm their first three appointments after their initial appointment in order to establish themselves as responsible patients. If they fail to confirm the first restorative appointment, then ALL future appointments will be cancelled. This will be considered their first failed appointment without being charged a $75.00 reschedule fee. If they do reschedule after failing their first appointment they must confirm the first three appointments. The second time that they fail, ALL future appointments will be cancelled, and they will need to pay a $75.00 reschedule fee. If they fail a third time they will be dismissed from the dental practice.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, never hesitate to ask.

I have read and understand this document in its entirety; outlining the office appointment policies of Star City Family Dentistry, Inc.

_____ _____

Patient signature or (Parent/ Legal Guardian if minor) Date

_____ _____

Witness of Star City Family Dentistry, Inc. Date

Star City Family Dentistry, Inc.

Financial Agreement

Since we are a dental provider for most insurance carriers, we will submit your insurance claims for you. However, your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for any co-payment (patient portion of percentage not covered by insurance carrier) and deductibles. Due to the constantly changing insurance contracts, benefits and deductibles, we are only able to estimate your insurance coverage. Although we estimate your insurance benefits we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusion, and waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

Payment for co-payments/deductibles or other charges are due at the time of service. We accept cash, checks, Visa, Master Card and American Express

Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance carrier if this applies to you.

There are many factors in determining patient responsibility where coordination of benefits between two insurance carriers are involved. We will provide you with the most accurate information available to us but CANNONT guarantee what your out of pocket expense will be.

All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance carrier 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. If the balance is not paid by the due date on the statement then all future appointments will be cancelled until balance is paid. It is the responsibility of the account holder to follow up with their own insurance carrier regarding the non-payment of the claim, (our office will try and assist you to the best of our ability if needed). Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past due accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge 1.5% per month, from the date of service, until the account is paid in full. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees. These collection fees will be added to the outstanding portion of the account and will also become the financial responsibility of the account holder. If your account is sent to collections, the patient and any patients connected to the account, will be dismissed from the practice and will not be accepted back into the practice.

Patients that do not have insurance are required to pay the entire amount of treatment charges at time of treatment and will receive a 5% discount.

I understand my financial obligation as outlined above. I am aware that any balance outstanding after sixty (60) days is my responsibility and if it is due to an insurance matter, I am responsible for resolving the issue.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness for Star City Family Dentistry, Inc. Date

OUR OFFICE NOW UTILIZES AN AUTOMATED SYSTEM TO CONTACT OUR PATIENTS. PLEASE ENSURE THAT OUR OFFICE HAS YOUR CELL PHONE TELEPHONE NUMBER AND E-MAIL ADDRESS.

AFTER OCTOBER 1, 2018, WE WILL NO LONGER MAKE "REMINDER" TELEPHONE CALLS OR SEND RECALL POSTCARDS TO PATIENTS.

THIS NEW SERVICE ALSO ALLOWS YOU TO MESSAGE US BACK DURING THE DAY WHEN YOU MAY NOT BE ABLE TO GET THROUGH ON OUR TELEPHONE LINES.

PLEASE ALSO NOTE THAT WE CAN CUSTOMIZE YOUR PREFERENCES AT TO FREQUENCY OF YOUR AUTOMATED REMINDERS.

WE APPRECIATE YOUR ASSISTANCE AND PATIENCE WHILE WE START UTILIZING THIS NEW SYSTEM.

PATIENT NAME: _____

EMAIL ADDRESS: _____

CELL PHONE NUMBER: _____