

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

SEX: _____ 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: _____

Who 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 to receive correspondences 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 : _____

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 _____
- 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
- Acrylic
- Metal
- Latex
- Local Anesthetics
- Other If yes, please explain: _____

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

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

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

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

I hereby authorize 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. Dr. Nail 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 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

Gary Nail D.D.S. and Jim Nail D.D.S.

Dental Insurance "Signature on File" Form

Patient Name: _____ please print

** Please SIGN in BOTH places below **

PRIMARY DENTAL INSURANCE:

Insured party: _____ Employer: _____

Social Security # or Ins. ID #: _____ Group or Policy #: _____

SECONDARY DENTAL INSURANCE, if any:

Insured party: _____ Employer: _____

Social Security # or Ins. ID #: _____ Group or Policy #: _____

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

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 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

Gary Nail D.D.S. and Jim Nail D.D.S.
1200 E. Woodhurst Dr., M-400
Springfield, MO 65804

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, or it has been made available to me. I understand that I may request a copy of this privacy policy, if desired.

Signature Date Please PRINT name here

Space Below For Office Use Only

- Individual refused to sign
Communications barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other (please specify):

J. G. NAIL D.D.S.

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.**

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 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 applicable law permits the changes. 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 this notice at any time. For information about our privacy practices or for additional copies of this notice please see the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. We may use your health information for treatment, or disclose it to a dentist, physician, or other health care provider providing treatment to you. An example of this would include an oral examination and report to a specialist.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. We may use or disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its activities. An example of this would be sending a statement of services for your dental visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality and competency assessment and improvement activities, auditing functions, cost-management analysis, customer service, and conducting training programs. We may use and disclose your health information for our health care operations. We may disclose your health care information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations, or to detect or prevent health care fraud and abuse. An example would be an internal quality assessment review.

We may also create and distribute "de-identified" health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards, or letters.

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 uses or disclosures permitted by your authorization while it was in effect.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist a person involved in your care, of your location and general condition.

We may use or disclose your health information to a public or private health entity authorized by law or by its charter to assist in disaster relief efforts.

We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness, or injury
- to report adult abuse, neglect, or domestic violence
- to health oversight agencies
- in response to court and administrative orders and other lawful processes
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person
- to coroners, medical examiners, and funeral directors
- to organ procurement organizations
- to avert a serious threat to health or safety
- in connection with certain research activities
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities
- to correctional institutions regarding inmates,
- as authorized by state worker's compensation laws

PATIENT RIGHTS

You have the right to look at or get copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage.

You have the right to receive an accounting of disclosures of protected health information after April 14, 2003. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you, or made at your request, or disclosures made to family members, or friends, in the course of providing care.

You have the right to request additional restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. If we do agree, we will abide by our agreement (except in an emergency), unless you agree, in writing, to remove it. Any agreement we make to a request must be made in writing and signed and dated by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

You have the right to a reasonable request that we communicate with you about your protected health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide a satisfactory explanation how you will handle payment under the alternative means or location you request.

You have the right to request that we amend your health information to correct incomplete or incorrect information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

You have the right to obtain a paper copy of this notice from us upon request.

For questions, or more information about this notice please contact the Privacy Officer of our office.

If you feel that your privacy protections have been violated, you have the right to file a written complaint with the Privacy Officer of our office, or with the Department of Health and Human Services, Office of Civil Rights, about the violations of the provisions of this notice or the policies and procedures of our office. 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 our office, or with the U. S. Department of Health and Human Services. (We will provide you with the address of the U.S. Department of Health and Human Services upon request.)

If you want to discuss a problem regarding the handling of your health information please contact the Privacy Officer for our office.

To be informed as to the current Privacy Officer for our office, please contact the Front Desk Manager of our office, during normal business hours, and she will provide you with assistance.

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(417) 881-1212