Name:_____

Birthdate:_____ **Age:**_____

Central Dental

Michelle L. Hasbrook, DMD

120 Atwater St. N
Monmouth, OR 97361
(503) 838-2998

DENTAL HISTORY

Reason for today's visit:_____

Former Dentist:_____City:_____

Date of last dental visit:_____Date of last dental X-rays:_____

Please check if you have or have had any of the following:

___ Bad breath	___ Sensitivity to sweets	___ Sensitivity when biting
___ Bleeding gums	___ Clicking or popping jaw	___ Sensitivity to hot & cold
___ Grinding teeth	___ Loose teeth or broken fillings	___ Food collection between teeth
___ Pain in mouth	___ Periodontal treatment	___ Sores or growths in your mouth

Are you satisfied with the appearance of your teeth?_____

Please rate your smile: 0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Physician's name:_____ Date of last physical:_____

Have you had any serious illness or operations? __ No / Yes__ If Yes, describe:_____

(Women) Are you pregnant? __No / Yes__ Nursing? __No / Yes__ Taking birth control pills? __No / Yes __

Do you require antibiotics prior to dental treatment? ___No / Yes___

Please check if you have or have had any of the following:

__ AIDS	__Circulatory problems	__Hepatitis	__Respiratory diseases
__ Alzheimers, dementia, memory loss	__Cortisone treatments	__High blood pressure	__Radiation treatment
		__High cholesterol	__Rheumatic Fever
__Anemia	__Cough, persistent	__HIV Positive	__Shortness of breath
__Artificial joints	__Diabetes	__Kidney disease	__Skin rash
__Artificial heart valve	__Epilepsy	__Latex allergy	__Stroke
__Asthma	__Fainting	__Liver disease	__Thyroid problems
__Back problems	__Fibromyalgia	__Mitral valve prolapse	__Tobacco habit
__Blood disease	__Glaucoma	__Nervous problems	__Tonsillitis
__Cancer	__Headaches	__Osteoporosis	__Tuberculosis
__Chemical dependency	__Heart murmur	__Pacemaker	__Ulcer
	__Heart problems	__Parkinson's disease	__Venereal disease
__Chemotherapy	__Hemophilia	__Psychiatric care	

Other? Describe:_____

MEDICATIONS:_____ **ALLERGIES:**_____

_____ _____

_____ _____

AUTHORIZATION AND RELEASE:

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient, or of parent if patient is a minor Date

Payment is due in full at time of treatment unless prior arrangements have been approved.

PATIENT INFORMATION

Patient's Name:_____ Birthdate:_____ Age:_____

Address:_____City:_____State:____ Zip:_____

Home Phone:_____ Daytime phone:_____ Mobile:_____

Email: _____

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

RESPONSIBLE PARTY INFORMATION

Name:_____Marital Status:_____

Address:_____City:_____State:____ Zip:_____

Mailing address:_____

Home Phone:_____ Daytime phone:_____ Mobile:_____

Relationship to Patient:_____ Birthdate:_____ Social Security No:_____

Employer:_____Occupation:_____No. Years Employed:_____

Spouse's Name:_____

Employer:_____Occupation:_____No. Years Employed:_____

Daytime Phone:_____Birthdate:_____ Social Security No:_____

INSURANCE INFORMATION

Policy Holder's Name:_____ Birthdate:_____

Address:_____City:_____State:____ Zip:_____

Home Phone:_____ Daytime phone:_____ Mobile:_____

Insurance Company:_____Insurance ID No:_____ Group No:_____

Insurance Co. Address:_____Insurance Co. Phone:_____

Policy Holder's Employer:_____

Does the patient have dual coverage? ___No / Yes___ If Yes, please complete the information below.

Policy Holder's Name:_____and Insurance ID No:_____

Insurance Company:_____Group No:_____Union Local No:_____

Insurance Co. Address:_____Insurance Co. Phone:_____

EMERGENCY INFORMATION

Name of nearest relative not living with patient:_____

Complete address:_____

Phone No:_____Relationship:_____

_____ _____

Patient Signature, or Parent's signature if patient is a minor **Date**

Mid-Valley Dental Associates

Michelle L. Hasbrook, DMD

120 Atwater St. N
Monmouth, OR 97361
503-838-2998

FINANCIAL AGREEMENT & POLICIES

This statement is to inform you of our financial policy. We are committed to providing you with the finest quality care using only the best material and technology available in the market today. All charges you incur are your responsibility regardless of your insurance coverage.

Insurance coverage is a valuable asset in restoring and maintaining good oral health. By providing us with accurate insurance information, you enable us to process your claims in a timely manner. We may also be able to determine benefits prior to treatment, which provides you with important deductible and co-payment information. Our relationship is with you as our patient, not the insurance company. Our office is not a party to that contract and final responsibility of payment is yours. As a courtesy to you, we will help you process your insurance claims. If there is no payment from the insurance company within sixty (60) days, you will be expected to pay the balance in full.

Your portion of the payment is due at the time that services are rendered. We accept cash, money orders, personal checks, Visa, MasterCard, American Express and Discover. We also offer no interest and low interest extended payment plans through Care Credit.

Returned checks for any reason, will be assessed a processing fee of $25.00. Balances older than 60 days are subject to collection fees and finance charges at the rate of 18% annually. NOTE: If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and collection costs.

All missed appointments (those without 24 hours notice) will be assessed a charge of $50.00.

I have read the above statement of the Financial Agreement and Policies, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

Signature_____**Date**_____

Mid-Valley Dental Associates

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 9/23/2013 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, 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 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 health care operations. For example, health care 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 decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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 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 authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of 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. We may contact you to provide you with information about our 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.

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 request. However, if we are unable to contact you using the ways or locations you have requested, we contact you using the information that we have.

Amendment. You have the right to request that we amend our 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 website or by electronic mail (e-mail).

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 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 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.

Our Privacy Official: Mandy Dittmer Telephone: 541-928-2301 Fax: 541-928-8493

Address: 2825 SW Willetta St. Suite A, Albany, OR 97321 Email: midvalleydental@gmail.com

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

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Program 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) _____

_____