# PATIENT INFORMATION

Patient's full name ______________________ Today's Date __________

SS#______________ Birthdate __________ Age _____ Sex _____ WT _____

Patient's address ______________________ City __________ State _____ Zip _______

Home phone # __________ Cell phone # __________ Work phone # __________

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

Person to contact in case of emergency ______________________ Phone __________

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## GUARANTOR/PARENT: ☐ same as above

Guarantor/Parent Name ______________________ Relationship to patient __________

Address ______________________ City __________ State _____ Zip _______

Phone __________ Date of Birth __________ Social Security # __________

Employer __________ Employer Telephone __________

## INSURANCE TO BILL:

☐ Medicare #______________ ☐ Medicaid #______________

☐ Private Insurance (Complete lines below fully):

**Primary Insurance Name** ______________ ☐ Medical ☐ Dental

Subscriber's name ______________________ Relationship to patient __________

Subscriber's address ______________________

Social Security # __________ Group # __________ Date of Birth __________

Employer __________ Employer phone # __________

**Secondary Insurance Name** ______________ ☐ Medical ☐ Dental

Subscriber's name ______________________ Relationship to patient __________

Subscriber's address ______________________

Social Security # __________ Group # __________ Date of Birth __________

Employer __________ Employer phone # __________

Our fees are due when services are rendered. If other arrangements are necessary, they need to be made before service is rendered. While we will assist you in filing any insurance claims, the entire amount of our fees is the patient's responsibility. Any amount failed to pay or contested or denied by the insurance company is between the patient and the insurance company. As a part of our analysis of your credit standing, we may request an investigative consumer credit report.

Any patient account unpaid after 60 days from the date of service may be charged interest at the rate of 1.5% per month. In case of failure to pay, we reserve the right to add additional costs like, but not limited to, reasonable collection fees, finance charges, late fees, court costs and attorney's fees. These costs are also the patient's responsibility. Thank you.

Signature of patient: ______________________

Signature of responsible party (parent/guardian/POA): ______________________

# - PATIENT MEDICAL INFORMATION -

Please Circle
Yes or No

1. Has there been any change in your general health in the past year? ........ Y N
2. My last physical examination was on ______
3. Are you now under the care of a physician? ........ Y N
   a.) If so, what is the condition being treated. ______
4. Have you had any serious illness or operations? ........ Y N
   a.) If so, what was the illness or operation. ______
5. Have you been hospitalized or had a serious illness within the past 5 years? ........ Y N
6. Do you have or have you ever had any of the below diseases or problems? ........ Y N

Rheumatic Fever    Heart disease    Cardiovascular diseases    Heart Attack    High blood pressure

Stroke    Asthma    Seizures    Diabetes    Hepatitis    Latex Allergy

Stomach ulcers    Kidney trouble    Venereal disease    Anemia    Abnormal bleeding

Artifical Joints or Heart Valves    Heart murmur    Mitral Valve Prolapse    Tuberculosis

7. Do you have any disease, condition, or problem not listed above that you think we should know about? ........ Y N
8. Do you have AIDS or have you been tested positive for the AIDS virus? ........ Y N
9. Do you take?:    Coumadin    Plavix    Aspirin ........ Y N
10. Are you taking any drugs or medicines? ........ Y N
    a.) If so, what medications. ______
11. Are you allergic to any medications? ........ Y N
    Please list ______

    ______
12. Have you had any serious trouble associated with any previous dental treatment? ........ Y N
    a.) If so, explain ______
13. Are you pregnant? ........ Y N
14. Do you smoke? ........ Y N
15. Have you ever had a problem with drug or substance abuse? ........ Y N
    a.) If so, explain ______

Please complete the following:

PHYSICIAN: ______

DENTIST: ______

REVIEWED BY: Dr. ______

Form Updated ______ ______

(dates initials) ______ ______

## SIGNATURE ON FILE

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ________________________________, hereby authorize

________________________________, to pay and hereby assign directly to William E. Paul, D.D.S., P.C. all medical and dental benefits, if any, otherwise payable to me for services as described on the attached forms. I understand I am financially responsible for all charges incurred less any dental insurance benefits when received by and paid to William E. Paul, D.D.S., P.C.

Authorization is hereby given to release all information necessary to the payment of said benefits.

Authorized Signature of Covered Person/Employee:

X________________________________________ Date_______________

926 East LaSalle | South Bend, Indiana 46617-2887 | ph 574.233.7700 | 1.800.274.2429 | fx 574.233.8264

# NOTICE OF PRIVACY PRACTICES

William E. Paul, DDS, PC
926 East LaSalle
Indiana, 46617

THIS NOTICE DESCRIBES HOW HEALTH AND MEDICAL 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 AND MEDICAL INFORMATION IS IMPORTANT TO US.

## OUR RESPONSIBILITIES

We at William E. Paul, DDS, PC understand that medical information about you and your health is personal. Applicable federal and state law requires us 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 06/01/2016, and will remain in effect until we replace it. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 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 this Notice, please contact us using 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 healthcare operations. For example:

**To Treat You:** We can use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Billing and Payment For Services:** We can use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We can use and disclose your health information in connection with our healthcare operations which 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 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 hearth 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 another 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, of 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 circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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 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 purposes without your written permission.

**Required by Law:** We may use or disclose your health information when we are required to do so by state or federal law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy 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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Respond to organ and tissue donation requests:** We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:**

* For workers' compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages 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, mailing, 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 an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, 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 April 14, 2003. 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 at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation 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 (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 hearth 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/prtvacy/hipaa/complaints/.

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.

Privacy Officer: **Cassandra T.**
Telephone: **(574) 233-7700**
Fax: **(574) 233-8264**
E-mail: williamdds296@hotmail.com
Address: 926 East LaSalle
City: South Bend
State: Indiana
Zip Code: 46617

**William E. Paul, DDS, PC - 926 East LaSalle**

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I,______________________________have been informed of this office's Notice of Privacy Practices.

______________________________________________
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
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

______________________________________________

______________________________________________

______________________________________________

**Authorization Form for Use or Disclosure of Patient Information**

**William E. Paul, D.D.S, P.C.**

Patient Name:_______________________________ Patient's Date of Birth:_______________

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Authorization. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your PHI. A copy of our Notice accompanies this Authorization. We encourage you to read it carefully and completely before signing this Authorization.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your PHI that we maintain. I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs: 7 years from your last account activity

You may obtain a copy of our Notice of Privacy Practices at: 926 E Lasalle Ave, South Bend, IN 46614

I understand that I may revoke this authorization at any time by following the directions in the Notice of Privacy Practices. I understand that my revocation must be in writing. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

**Signature of Patient or Patient's Personal Representative:**

_________________________________________Date_______________

If Personal Representative:

Print Name:_____________________________________________

Signature:___________________________Relationship to Patient:_____________

**Please list any individual you feel we are able to disclose medical and financial information:**

**Name** **Relationship** **Phone Number**

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

**Specific description of the patient information to be used or disclosed:** Request for patient's radiographs to be sent unencrypted electronically
**Purpose(s) of this use or disclosure:** Patient's treatment, payment activities and healthcare operations
**Initials:**__________