Allen
FAMILY DENTISTRY

Mary Disa Allen, DDS, PC
6232 Peters Creek Road
Roanoke, VA 24019
(540) 362-3846

Patient Information

Today's Date _____
Name _____ Home Phone (_____)_____
How do you wish to be addressed? _____ Cell Phone (_____)_____
Street _____ Work Phone (_____)_____
City _____ State _____ Zip _____ SSN# __ __ __-__ __-__ __ __ __
Date of Birth ____ / ____ /_____ Age _____ Gender _____ Email _____
Emergency Contact _____ Relation _____ Emergency Phone_____
How did you hear about us? _____
Do we have permission to leave messages about our dental appointments? Yes ☐ No ☐
Best contact number to leave messages: Cell phone ☐ Home phone☐

Responsible Party

Guarantor's Name _____ Phone Number (_____) _____
Address _____City _____ State _____Zip_____
(If different from above) _____
Patient Relation to Guarantor _____ Guarantor Employer _____
Employer Address _____City _____ State _____ Zip_____
Guarantor SS#: __ __ __ - __ __ - __ __ __ __ Guarantor Birth Date ____ / ____ / _____

Insurance Information

Do you have Dental Insurance? Yes ☐ No ☐ Name of Insurance Company_____
ID Number _____Group Number _____
Policy Holder _____ Subscribers DOB ___ /___ /_____
Subscriber's Workplace _____
Subscriber's Phone Number _____ Subscriber's SSN __ __ __-__ __-__ __ __ __
Relationship to Subscriber _____

Dental History

1. What is your biggest concern about your gums, mouth or teeth? .....
2. When was your last visit to your family dentist and what was the nature of the treatment?.....
3. Have you had periodontal treatment before? If yes, when and where? Yes☐ No☐.....
4. How often and when is the last time your teeth were cleaned?.....
5. Approximately when were your last dental x-rays?.....

Please check the following conditions if they apply to you:

☐ Swollen or bleeding gums	☐ Bad breath or mouth odors	☐ Bad tastes
☐ Painful gums or teeth	☐ Sensitivity to hot, cold, or sweets	☐ Clenching or grinding your teeth
☐ Loose teeth	☐ Increasing spaces between teeth	☐ Other _____

Have you been treated for thin bones (**osteoporosis, osteopenia**)? Yes☐ No☐
If yes, please circle the following medications you are taking:
Fosamax Actonel Boniva Didronel Skelid Zometa Aredia Ostec

Medical History

Please check in the YES or NO boxes:

	YES	NO
Are you allergic to any medications? If yes, what? ……	☐	☐
Have you had any serious illness, operation or hospitalization in the past? Reason: ……	☐	☐
Has there been a change in your health in the last 2 years?.....	☐	☐
Are you a "bleeder" or have you had excessive bleeding following a dental treatment?.....	☐	☐
Do you smoke or use tobacco products? How much?..... How long?.....	☐	☐
Do you drink alcoholic beverages? ……	☐	☐
Have you had Cancer? Please describe.……	☐	☐
Do you have any artificial joints? Please describe. ……	☐	☐
Have you ever been diagnosed with obstructive sleep apnea? ……	☐	☐

Who is your physician? _____
Where is your physician located? _____ Phone _____
When was your last physical exam? _____

Have you had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Angina	☐	☐	AIDS or HIV	☐	☐
Heart Murmurs	☐	☐	Heart Attack	☐	☐	Blood Disorders	☐	☐
Mitral Valve Prolapse	☐	☐	Pacemaker	☐	☐	Nervous Disorders	☐	☐
Rheumatic Fever	☒	☐	Emphysema	☐	☐	Epilepsy/Seizures	☐	☐
Heart Problems	☐	☐	Asthma	☐	☐	Steroids Last 2 Years	☐	☐
Heart Bypass Surgery	☐	☐	Dialysis	☐	☐	Radiation/Chemo	☐	☐
Kidney Disease	☐	☐	Tuberculosis	☐	☐	Bleeding Problems	☐	☐
Chemical Dependency	☐	☐	Stroke	☐	☐	Other _____		
Hepatitis/Liver Disease	☐	☐	Diabetes	☐	☐	**WOMEN ONLY** Are you:		
Oral Surgery Complications	☐	☐	Arthritis	☐	☐	Pregnant?	☐	☐
Thyroid Disorders	☐	☐	Headaches	☐	☐	Breast Feeding?	☐	☐

List **ANY** drugs or medications that you are currently taking.

_____ _____
_____ _____
_____ _____
_____ _____

PATIENT SIGNATURE: _____ DATE: _____

For Office Use:
MEDICAL HISTORY REVIEWED ON: _____ BY: _____

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Notice of Privacy Practices

THIS 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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Allen Family Dentistry ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Allen Family Dentistry at:

6232 Peters Creek Rd
Roanoke, VA 24019
(540) 362-3846
info@allenfamilydentistry.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on April 1, 2017.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is April 1, 2017.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

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General Consent and Acknowledgements

A copy of the Notice of Health Information Privacy Practices (HIPPA) is posted for your review. Please sign below acknowledging you have been provided and have reviewed the policy.

Signature _____ Date _____

General Consent to Treat

By becoming a patient of Allen Family Dentistry and presenting myself for appointment with the dentist or dental hygienist of Allen Family Dentistry, I consent to and authorize treatment by the qualified care providers of Allen Family Dentistry. Qualified care providers are defined as dentists, dental hygienists, dental assistants. I hereby agree that the providers may examine me, perform non-invasive diagnostic tests and treatments. I acknowledge that should additional treatment be prescribed, I will sign a separate authorization for any invasive diagnostic tests or dental procedures to be performed.

Signature _____ Date _____

Release to Bill Insurance

I hereby authorize Allen Family Dentistry to release information to my insurance company. I hereby assign and direct payment to Allen Family Dentistry of the benefits herein specified and otherwise payable to me but not to exceed the doctor's regular charges for this treatment or surgical procedures. ***I understand I am responsible to Allen Family Dentistry for the charges/charged amounts not covered by this agreement.***

Signature _____ Date _____

Exposure Consent

Virginia State law provides that when a healthcare worker is exposed to the bodily fluids of another person in a manner which may transmit human immunodeficiency virus (HIV- the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to testing for HIV, or other communicable diseases and to release of the results to the exposed person and the local health department.

Signature _____ Date _____