LEWIS FAMILY DENTAL

PATIENT INFORMATION

Name: _____ Date: _____
Last First MI

Social Security #: _____ Birth Date: _____

Phone(Home): _____ (Work): _____ (Cell):_____

Email Address:_____

Address: _____
Street Apartment #

_____
City State Zip Code

How would you like to be contacted? Circle: Phone Email Text messaging

Check Appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

College Student □ F.T. □ P.T., Name of School: _____City:_____ State:____

Employer:_____ Work Phone :_____

Spouse or Parent's/Guardian's Name: _____ Date of Birth:_____

Spouse or Parent's/Guardian's Employer:_____ Work Phone: _____

Whom may we thank for Referring you?_____

Person to contact in case of an Emergency:_____ Phone:_____

RESPONSIBLE PARTY

Is the Patient the Person Responsible for this Account (circle one): YES NO

If NOT, who is the Person Responsible for this Account:_____
Last First MI

Relationship to Patient: _____Birth Date:_____ SS#: _____

Address:_____ Phone: _____

Employer:_____ Work Phone:_____

Is this Person currently a Patient in our office? □Yes □ No

INSURANCE INFORMATION

Name of Insured:_____Relationship to Patient:_____

Birth Date:_____ SS#:_____Date Employed:_____

Name of Employer: _____Union or Local #:_____Work Phone:_____

Insurance Co.: _____ Phone: _____Group #: _____Policy/I.D. #: _____

Ins. Co. Address: _____City:_____ State:_____ Zip Code: _____

What is your plan's annual maximum benefit? _____

How much of the annual maximum have you used to date? _____

How much is your annual deductible? _____

How much has been applied to this deductible? _____

Are there any waiting periods included in your plan? _____

If so, what are they? _____

Do you have Additional Insurance? □ Yes □ No

PATIENT'S DENTAL HISTORY

Reason for this Visit: _____

When was your last Dental Visit: _____

What was done at this Visit? _____

How often did you visit the Dentist before then: _____

Have you had a complete series of dental films (x-rays) taken? When/Where:

_____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Is your drinking water fluoridated? (Circle one) YES NO

If you could change anything about your smile, what would you change?

_____

_____

_____

_____

DENTAL HISTORY (cont'd)					
	YES	**NO**		**YES**	**NO**
Do your gums bleed while brushing?			Have you ever had any head/neck/jaw injuries?		
Are your teeth sensitive to hot or cold liquids/foods?			Have you noticed loosening of your teeth?		
Are your teeth sensitive to sweet or sour liquids/foods?			Have you ever had periodontal treatment?		
Do you feel pain to any of your teeth?			Have you ever experienced any of the following in your jaw?		
Do you have any sores or lumps in or near your mouth?			Clicking……		
Do you bite your lips or cheeks often?			Pain (joint, ear, side of face)……		
Does food tend to become caught in your teeth?			Difficulty opening or closing…		
Have you ever worn a bite plate or other appliance?			Difficulty chewing……...		
Have you ever had any difficult extractions in the past?			Do you have frequent headaches?		
			Do you clench or grind your teeth?		
HEALTH HISTORY					
Are you in good health?			Do you bruise easily?		
Have there been any changes in your general health in the past year?			Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing Bisphosphonates?		
Are you under the care of a physician?			Do you use tobacco?		
Date of your last physician's exam: _____			Do you or have you used controlled substances?		
Physician's Name:_____ Phone: _____			**WOMEN ONLY:**		
Have you ever been hospitalized for any surgical operation or serious illness? Please explain: _____			Are you pregnant or think you may be pregnant? Due Date: _____		
Are you taking any medications including non-prescription medication?			Are you nursing?		
Have you had any abnormal bleeding?			Are you taking birth control pills?		

Are you taking any medications, herbal supplements, or vitamins? □YES □ NO

If yes, please explain: _____

_____

Do you or have you ever had any of the following:	YES	NO		YES	NO
Rheumatic Heart Disease?			Kidney problems?		
Rheumatic fever?			Cough that produces blood?		
Scarlet Fever?			Persistent cough, tuberculosis?		
Heart defect, heart murmur or mitral valve prolapse?			Chemotherapy?		
Pacemaker or heart surgery?			Sexually transmitted diseases?		
High/Low blood pressure?			Epilepsy or seizures?		
Swelling of feet, ankles or hands?			Anemia?		
Hepatitis, Jaundice or liver disease?			Glaucoma?		
Stroke?			Nervousness?		
Sinus problems or allergies?			Tonsillitis?		
Lung, Asthma or Hay fever?			Tumors?		
Hives or skin rash?			Mental health problems?		
Diabetes, hypoglycemia?			Back problems?		
Aids or HIV Infection?			Chemical Dependency?		
Thyroid problems?			Cortisone treatment?		
Arthritis or rheumatism?			Cold sores/fever blisters?		
Joint replacement or Implant?			Eating disorders?		
Stomach ulcer?			Other? _____		
Are you Allergic to or have you had reactions to:			Aspirin?		
Local Anesthetics like Novocain?			Iodine?		
Penicillin or other Antibiotics?			Any metals (E.G., Nickel, mercury, etc)		
Sulfa drugs?			Latex/rubber		
Barbiturates, sedatives or sleeping pills?			Other, please list: _____ _____ _____		

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist and dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered on my behalf of my dependents.

X _____ **Date** _____

Signature of patient or parent/guardian if minor

CONSENT FOR SERVICES

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
- Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements have been satisfied.
- I understand that the fee estimates listed for this dental care can only be extended for a period of six months from the date of the patient examination.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you or your assignee, to telephone me at my home, work or cell phone number to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, Parent or Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

**You may refuse to Sign this acknowledgment

I, _____, have received a copy of Lewis Family Dental's Notice of Privacy Practices.

_____ _____

Signature Date

LEWIS FAMILY DENTAL, P.C.

PAYMENT POLICY

To Our Valued Patients:

Thank you for choosing Lewis Family Dental, P.C. to help you meet your oral health goals. Our mission is to deliver the best and most comprehensive dental care available and an important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible.

1. **Payment is expected at the time the services are rendered**. We accept cash, personal checks, Visa, MasterCard, and Care Credit.

2. **Non-insured patients are expected to make payment in full on the date services are rendered, unless definite arrangements have been made with Dr. Lewis or our office manager in advance.**

3. **Patients with dental insurance are expected to pay, on the day of service, that portion of the total fee not covered by insurance**. This "patient portion" is ONLY an estimated dollar amount.

As a courtesy, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow; HOWEVER, if we do not receive payment from your insurance company within 60 days, the payment becomes your responsibility.

4. **The patient is always responsible for seeing that the ENTIRE FEE is paid in full**.

5. **Appointments cancelled or missed without 24-hours notice will result in a $25 charge**.

6. **Lewis Family Dental, P.C. charges a $25 fee for returned checks**.

I have read the above policies and agree to abide by them.

Signed: _____ Date: _____

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We use and disclose your medical records for the purposes of treatment, payment, and health care operations.

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services. An example of this 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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer at the address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, and any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- The right to provide a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Rusty O. Lewis, D.D.S
8330 Dawson Creek Bay
Lincoln, NE 68507
(402) 325-6056

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
1-877-696-6775 (toll free)