

Notice Of Privacy Practices Acknowledgement

Dr. Rhonda Nielsen

621 N. Virginia St.

(361)552-6814

Fax (361)552-8193

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restriction.

- I agree to be responsible for all charges for dental services and materials not paid by dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
- I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

PLEASE BE ADVISED THAT DR. NIELSEN IS ONLY A PARTICIPATING PROVIDER FOR UNITED CONCORDIA INSURANCE, CIGNA AND METLIFE. ALL OTHERS PLEASE NOTE THAT YOU ARE VISITING AN OUT OF NETWORK PROVIDER/DENTIST AND WILL BE RESPONSIBLE FOR THE DIFFERENCE IN BILLING.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE _____

SIGNATURE: _____

Nielsen Family Dental

621 N. VIRGINIA ST
PORT LAVACA, TX 77979
361-552-6814

Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, and insurance providers unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included: their name must be explicitly stated below.** You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friends (including spouse)

I give the following named person(s) authorization to speak with the office of Port Lavaca Family Dentistry, on my half regarding **(please check all items authorized)**.

Name of authorized person(s): _____ Relationship _____
Phone number _____
___ Appointments ___ Financial ___ Dental Treatment ___ Insurance ___ Other (explain) _____

Name of authorized person(s): _____ Relationship _____
Phone number _____
___ Appointments ___ Financial ___ Dental Treatment ___ Insurance ___ Other (explain) _____

Name of authorized person(s): _____ Relationship _____
Phone number _____
___ Appointments ___ Financial ___ Dental Treatment ___ Insurance ___ Other (explain) _____

___ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare providers should I wish to change one or more contacts listed above.

Patient's Name _____

Date of birth _____

Signature of patient or patient's authorized representative

Date _____

Nielsen Family Dental

Non-Covered Services Acknowledgement Form

I, _____ understand that the services performed by and/or supplies prescribed by **Dr. Rhonda Nielsen** may not be considered eligible for benefits by my insurance company. I understand that my insurance coverage has certain restrictions, as well as non-covered services and supplies. I understand that the **treatment plan** I am given is strictly an **estimate**.

Nearly all dental benefit plans are the result of a contract between the plan sponsor (usually an employer or a union) and the third-party payer (usually an insurance company). **The amount the plan pays is determined by the agreement negotiated by the employer with the insurer.** Dental coverage is determined not by the patient's dental needs, but by how much the employer contributes to the plan.

If my dependent or I choose to receive the services and/or supplies prescribed by **Dr. Rhonda Nielsen** and they are not covered by my insurance, I agree in advance to accept full financial responsibility for all costs associated with the non-covered services

PATIENT/GUARDIAN SIGNATURE

PATIENT DATE OF BIRTH

PRINTED NAME

DATE

NIELSEN FAMILY DENTAL
PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU - THANK YOU

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ INITIAL _____

How do you wish to be addressed? _____ Date of Birth: _____

Single Married Divorced Separated Widowed Male Female

Social Security # _____ - _____ - _____ Driver's License # _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____

Employer _____ Occupation _____

ID# _____ Ins. Phone Number _____

Dental Insurance Co. _____ Group # _____

How did you hear about our practice? Whom may we thank for your referral? _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT):

LAST NAME _____ FIRST NAME _____ INITIAL _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____

Employer _____ Occupation _____

Dental Insurance Co. _____ Group # _____

ID# _____ Ins. Phone Number _____

Emergency contact name _____ Phone# _____ Relation _____

How would you prefer to be contacted regarding upcoming appointments? Email Text Phone call

Patient Name:

Birth Date:

Date Created:

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, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic

Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

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	Radiation Treatments <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	Recent Weight Loss <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	Renal Dialysis <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	Rheumatic 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	Rheumatism <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	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <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	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <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	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <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	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <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	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <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	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <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	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <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	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <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	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <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	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <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	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <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
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <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
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

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

Signature of Patient, Parent or Guardian: _____

X _____ Date: _____