# BOND 20/20 DENTAL

915 South Ironwood Drive
South Bend, IN 46615

# PATIENT REGISTRATION

**Patient's Name** | **Birth date** | **Age** | **Sex: M F**

| **Home Address** | **City** | **State** | **Zip** |
|---|---|---|---|

| | | |
|---|---|---|
| **Home Phone #**<br>**Work Phone #**<br>**YOUR cell phone #** | ***Please Circle One:***<br>Single, Married, Separated, Widow | **Your Soc Sec. # ( is not necessary if paying at the time of service)** |
| **Your Employer** | | |
| **Occupation** | | |

**Are you a full time student?**
☐ Yes ☐ No

*If patient is minor we need:* *Mother's Name & Birth date* *Father's Name & Birth date*

**Person paying this bill** **YOUR Driver's License Number**

**Name of spouse ( or parent if minor)** **YOUR E-mail address**

**Spouse's ( or parent's) employer** **Spouse's Soc. Sec. #** **Work phone #**

## EMERGENCY INFORMATION

*Name, Address, & Telephone of A relative not living with you*:

## How did you hear about our office?

## Reason for your visit today ?

| **DENTAL INSURANCE INFORMATION (Primary Carrier)** | **If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)** |
|---|---|
| **Insured's name DOB SS#** | Insured's name DOB SS# |
| **Insured's employer** | Insured's employer |
| **Insurance Co** | Insurance Co |
| **Insurance Co Address** | Insurance Co Address |
| **Phone #** | Phone # |
| **Group # Policy #** | Group # Local # |

**Patient Signature (or Parent of Child)** **Date** **Dentist's Signature**

# DENTAL HISTOY

| Please check the following : | YES | NO |
|---|---|---|
| -Sensitivity (hot, cold, sweet) Where? UR LR UL LL | ☐ | ☐ |
| -Headaches, ear aches, neck or jaw joint pain | ☐ | ☐ |
| -Mouth ulcers or cold sores | ☐ | ☐ |
| -Teeth or fillings breaking | ☐ | ☐ |
| -Grinding or clenching teeth | ☐ | ☐ |
| -Bleeding, swollen or irritated gums | ☐ | ☐ |
| -Loose, tipped or shifting teeth | ☐ | ☐ |
| -Bad breath | ☐ | ☐ |
| **Do you have or have you had any of the following?** | | |
| -Dentures | ☐ | ☐ |
| -Partial dentures | ☐ | ☐ |
| -Braces | ☐ | ☐ |
| -Gum treatments | ☐ | ☐ |
| **Please share the following dates:** | | |
| -Your last cleaning | ___ / ___ | |
| -Your last oral cancer screening | ___ / ___ | |
| -Your last complete X-Rays | ___ / ___ | |

**Name of Previous Dentist** _____

**City** _____ **State** _____

**Phone Number** _____

**What is the most important thing to you about your future smile and dental health?** _____

| | YES | NO |
|---|---|---|
| **If you could whiten your teeth for a cost anyone could afford, would you do it?** | ☐ | ☐ |
| **Do you smoke or use chewing tobacco?** How much? For how long? | ☐ | ☐ |
| **If I could change my smile, I would:** | | |
| -Make my teeth whiter | ☐ | ☐ |
| -Make my teeth straighter | ☐ | ☐ |
| -Close spaces | ☐ | ☐ |
| -Replace metal fillings with tooth colored restorations | ☐ | ☐ |
| -Repair chipped teeth | ☐ | ☐ |
| -Replace missing teeth | ☐ | ☐ |
| -Replace old crowns that don't match | ☐ | ☐ |
| -Have a smile makeover | ☐ | ☐ |

**On a scale of 1 – 10, with 10 being the highest rating:**

-How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?**

_____

_____

**What is the most important thing to you about your dental visit today?** _____

# MEDICAL HISTORY

**Please check any of the following that apply to you:**

- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ OTHER (please list):

_____

_____

_____

_____

_____

_____

**For WOMEN Only**

- ❑ Birth Control Pills
- ❑ Breast-feeding
- ❑ Pregnant

1-3 mos,3-6 mos,6-9mos,

**Do you have an allergy to any of the following?**

- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Other: _____
- ☐ Latex _____
- ☐ Local Anesthetic _____
- ☐ Nitrous Oxide _____
- ☐ Penicillin _____

**What medications are you currently taking?**

_____

_____

_____

**Are you under a physician's care? For what?**

_____

_____

**Family Physician** _____ **Phone Number** _____

**We Should Know About?** _____ _____

*Is there any other* Medical or Dental Information

_____ _ _____ _____

# HIPAA NOTICE OF PRIVACY PRACTICES

John D. Bond, D.D.S Effective Date: March 26, 2013

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.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 574.288.5252.

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form. As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.

To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in should with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. Written authorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system as listed below:

1) Dentrix

VI. Our Duties.

We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.

You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.

You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: Carrie Brennan at 574.288.5252

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES AND

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**DR. JOHN BOND – BOND 20/20 DENTAL 915 S Ironwood Dr. South Bend, IN 46615 574-288-5252**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health to carry out treatment, payment activities and health care operations. I have reviewed a copy of this office's Notice of Privacy Practices.

## RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me, account and claims information. This information may be released to:

_____ Spouse _____

_____ Children _____

_____ Other _____

_____ INFORMATION IS NOT TO BE RELEASED TO ANYONE

## MESSAGES

Please call my: HOME_____ WORK_____ CELL_____

If unable to reach me: _____ You may leave a detailed message

_____ Please leave a message asking me to return your call

The best time to reach me is: Day _____ between (time) _____

**PATIENTS SIGNATURE _____ DATE _____**

If this Consent is signed on behalf of the patient, complete the following:

**REPRESENTATIVE'S NAME _____ RELATIONSHIP TO PATIENT _____**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. A COPY OF OUR PRIVACY PRACTICES IS AVAILABLE UPON REQUEST.

**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 ___ Communication barriers prohibited ___ An emergency situation prevented ___ Other _____

**AUTHORIZATION & ACKNOWLEDGEMENT**

I authorize Bond 20/20 Dental, LLC and staff to treat me and the person(s) for whom I have financial responsibility.

I understand I am Financially responsible for all services rendered and for charges not timely paid by my insurance company and understand that I am financially responsible for any balance not covered by the insurance company.

I understand that if my account at any time becomes more than sixty days delinquent an interest charge of 18% will be added monthly to my accounts remaining balance. The minimum finance charge is .50 cents and the minimum balance is $10.00. If your account becomes 90 days delinquent it will be subject to being placed with a collection agency.

The Responsible party is liable for all expenses incurred in collection procedures including collection fees of 40%, attorney fees, court costs, as well as the remaining balance on my account.

A service charge of $25 will be added for any check returned for NSF.

I authorize the insurance company to pay benefits directly to Fields 20/20 Family Dentistry.

I authorize the release of any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of this authorization shall be as valid as the original.

Guarantor's Signature _____

Print Guarantor's Name _____

PRINT Patient(s) names / relationship to patient(s)

_____

_____

_____

_____

_____

Date _____