"We think the world of your smile!"

Gray Family Dental, PA

PATIENT INFORMATION

Name ______________________________

I prefer to be called ______________ DOB ______________

Address ______________________________

City ______________ State __________ Zip __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Sex: ☐ Male ☐ Female

Patient SS# ______________________________

Occupation ______________________________

Employer ______________________________

Spouse/Parent Name ______________________________

Spouse/Parent DOB ______________________________

Spouse/Parent SS# ______________________________

Spouse/Parent Occupation ______________________________

Spouse/Parent Employer ______________________________

Whom may we thank for referring you? ______________________________

____

ACCOUNT INFORMATION

Who is responsible for this account?: ______________________________

Relationship to the patient?: ______________________________

Employer of Responsible Party: ______________________________

Insurance Company ______________________________

Group#: ______________________________

Subscriber's Name: ______________________________

DOB: ______________ SS#: ______________

Relationship to patient?: ______________________________

<u>I understand that I am responsible for all charges, regardless of insurance coverage or lack thereof.</u> If insured, I hereby authorize the release of all information necessary to secure payment of insurance benefits and assign payment of those benefits directly to Dr. Tamara Gray. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature

____

Relationship Date

CONTACT INFORMATION

Cell# ______________ Work# ______________ Home# ______________ Email address ______________ Spouse's work # ______________ Best time and number to reach you ______________________________

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name ______________________________ Relationship ______________________________

Cell # ______________ Home# ______________ Work # ______________

DENTAL HISTORY

Reason for today's visit ______________ .Reason for leaving last dentist ______________ .

What did you like most about your last dentist? ______________ Least? ______________

How Long since your last visit? ______________ Last cleaning? __________ How often do you brush? ______________

Floss? ______________ Other(i.e. Rinses, picks)? ______________

Former dentist ______________ City ______________ State ______________

Do you like the appearance of your teeth? ______________________________

Would you make any changes to your teeth (i.e. color, gaps, shape)? ______________________________

Have you ever had an upsetting dental experience? ______________________________

Do you have any special concerns about your visit? ☐ Nervous ☐ Time ☐ Cost ☐ Other ______________

Anything else you would like us to know? ______________________________

DENTAL HISTORY

Please mark “Yes” or “No” to indicate if you have, or have ever had, any of the following:

Bleeding Gums	☐ Yes	☐ No	Sensitivity to Sweets	☐ Yes	☐ No
Clicking/Popping Jaw	☐ Yes	☐ No	Sensitivity to Biting	☐ Yes	☐ No
Jaw Locked Open or Closed	☐ Yes	☐ No	Sensitivity to Cold	☐ Yes	☐ No
Food Collection Between Teeth	☐ Yes	☐ No	Sensitivity to Hot	☐ Yes	☐ No
Grinding/Clenching	☐ Yes	☐ No	Pain Around Ear	☐ Yes	☐ No
Wear a Night Guard	☐ Yes	☐ No	Gum Treatment	☐ Yes	☐ No
Gums Swollen/Tender	☐ Yes	☐ No	Sores/Growths in Mouth	☐ Yes	☐ No
Jaw Pain/Fatigue	☐ Yes	☐ No	Broken Teeth/Fillings	☐ Yes	☐ No
Loose Teeth	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name________________________Phone#___________________How long since last visit?___________

Please mark “Yes” or “No” to indicate if you have, or have ever had, any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Require Pre-Med	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Gum Treatment	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Sores/Growths in Mouth	☐ Yes	☐ No	Tumor or Growth	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Broken Teeth/Fillings	☐ Yes	☐ No	Sleep Apnea/C-PAP	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No	Snoring	☐ Yes	☐ No

Do you drink alcohol?____________________How often?______________Do you or have you used controlled substance?_________

Do you use tobacco?_____________________________How much per day?______________________Do you want to quit?_______

Type of to bacco: ☐ Cigarettes ☐ Cigar ☐ Pipes ☐ Smokeless

WOMEN: Are you pregnant?________________________How far along?___________________Nursing? ______________________

Hormone therapy?________________________Birth control?____________________

MEDICATIONS

Please list medications you are taking (prescription & over-the-counter)

____

____

____

Have you ever taken medication for osteoporosis?_______________

Pharmacy Name:______________________________________

Pharmacy Phone#:_____________________________________

ALLERGIES

☐ Aspirin ☐ Codeine ☐ Erythromycin

☐ Germicides/ Pesticides ☐ Latex ☐ Penicillin/Amoxicillin

☐ Sulfa ☐ Tetracycline ☐ Other

☐ **NONE**

The information I have provided on this form is complete, truthful and accurate. I understand that withholding pertinent information may prevent proper and/or optimal treatment.

____ _________________________________

Patient/Parent Signature *Date* *Tamara Gray, DDS*

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Payment Options:

• Payment is due at the time of service unless financial arrangements have been made prior to the appointment. All charges are the responsibility of the patient, regardless of insurance coverage or lack thereof. We accept cash, check, Visa, Master Card, American Express, and Discover.
• For those interested in extending payment over a longer period of time, we have interest free financing options through Care Credit available.

For those with dental insurance:

• Our office understands the value of insurance benefits and we gladly accept assignment of benefits as a courtesy to our patients.
• Rarely does an insurance company cover an entire bill. We will do our best to estimate your deductible and the portion that your insurance company will cover. However, any remaining balance is your direct responsibility. This includes any non-covered services,yearly deductible, or co-payments particular to your individual insurance plan.
• Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will cover. Since it would be impossible for us to be familiar with the details of every insurance plan, we ask that you be aware of your financial responsibilities under the terms of your policy. Bring us a copy of your benefit booklet if you would like help interpreting your benefits.
• Our office uses composite (tooth colored) filling, we do not use amalgam (silver) for fillings. Some insurances will apply an alternate benefit of silver filling for payment determinations. If your insurance company does not pay for a composite (tooth colored) filling, it is your responsibility to pay the difference in fees.
• While we are happy to work with you to maximize your insurance benefits, please remember that your insurance contract is between you, your employer, and the insurance company. You are privy to much more information about your coverage than we are. We have no control or input regarding decisions made by your insurance company.
• Insurance claims unpaid after 60 days become the responsibility of the patient. After 60 days, we require that you pay the outstanding balance. We will provide any necessary documentation to help you collect payment from your insurance company.

Important Information:

• If you are unable to honor your reserved appointment time, a minimum of 24 hours notice is required. A $25 fee may be charged if 24 hours notice is not received.
• In order to stay on schedule, patients who arrive late for an appointment may have to be rescheduled.

Minor Patients:

• Consent for treatment must be received from a parent or guardian for any patient under the age of 18.
• State law requires that a parent or guardian remain in the office while treatment is provided to a minor.

Informed Consent:

• I understand that the information that I have given today is correct to the best of my knowledge I also that it is my responsibility to inform this office of any changes in any medical status. I authorize the dental team to perform any necessary dental services, such as X-Rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. I authorize the doctor (and his/her employees for assistance when applicable) to perform any and all forms of treatment, medication and therapy with my informed consent in connection with my diagnosis and treatment plan.

I have read and understand the above information. I understand that I am responsible for any fees incurred.

______________________________ ________________________________

Printed Name Signature Date

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What you should know about dental Insurance...

We are an "In Network" provider for **Delta Dental PPO** plans and **Guardian PPO** plans ***ONLY***. All other insurance plans or policies are considered "Out of Network". As a courtesy to our patients, we will file your claim and accept assignment of benefits. We are able to file on your behalf as long as your contract insurance company allows you to choose your own doctor.

We try to gather as much information regarding your policy as possible. However, we are only able to acquire the information that your insurance company is willing to provide over the phone or by fax. Insurance companies are not often forthcoming with this information. We try to provide the most accurate estimate possible based on the information provided to us from the insurance company. Your insurance company will not guarantee payment until they process you claim. By law, your insurance company has 30 days to process the claim. If payment is delayed or denied, we may require your assistance. Ultimately you are responsible for any remaining balance, this includes any non-covered services, yearly deductible, or co-payment particular to your individual policy.

Although insurance companies often say you will receive "*two free cleanings*" per year-often they are never "*free*". They are 100% of the maximum allowed on your plan. The maximum allowed depends on how high your UCR (Usual, Customary & Reasonable Allowances) is. They also deduct the amount of your cleaning from your calendar year maximum.

Each plan is different. It is impossible for us to keep track of all the specifications and exclusions of every dental plan. We encourage you to become familiar with your dental plan and its conditions. We are always available to answer any questions you might have.

HIPAA PRIVACY NOTICE

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.

Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

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 or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Other Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of a criminal conduct

About criminal conduct on our premises

In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.
Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.

2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.

3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:

Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record

Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

Protected health information involving laboratory tests when your access is required by law

If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you

If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research

Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law

If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information

We may also deny a request for access to protected health information if:

A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person

The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person

The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:

Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment

Is not part of your medical or billing records

Is not available for inspection as set forth above

Is not accurate and complete

In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:

To carry out treatment, payment and health care operations as provided above

To persons involved in your care or for other notification purposes as provided by law

For national security or intelligence purposes as provided by law

To correctional institutions or law enforcement officials as provided by law

That occurred prior to April 14, 2003

That are otherwise not required by law to be included in the accounting

6. You have the right to request and receive a paper copy of this notice from us.

7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Acknowledgment of Receipt of HIPPA Privacy Policy

*You May Refuse to Sign This Acknowledgment

I,______________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date