PATIENT REGISTRATION

Welcome to our practice and thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us. We look forward to meeting you.

Patient First Name: _______________ Last Name: _______________ Middle Initial: _______
Patient is: ☐ Benefit Policy Holder ☐ Responsible Party   Preferred Name: _______________

PATIENT INFORMATION

Address: _______________ City: _______________ State: _______ Zip: _______
Home phone: _______________ Cell: _______________ Work: _______________ Ext: _______
Birth Date: ___/___/_____ Age: _______ SS #: ____-____-_____ Driver's License#: _______________ State: _____
Sex: ☐ Male ☐ Female   Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed ☐ Minor
Email: _______________ ☐ I would like to receive correspondence via email/text
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired   Employer/Occupation: _______________
Student Status: ☐ Full Time ☐ Part Time   School/Address: _______________
Emergency Contact Name: _______________ Phone: _______________ Relationship: _______________
Whom may we thank for referring you to our office? _______________

RESPONSIBLE PARTY (if someone other than the patient is responsible for billing)

First Name: _______________ Last Name: _______________ Middle Initial: _______
Address: _______________ City: _______________ State: _______ Zip: _______
Home phone: _______________ Cell: _______________ Work: _______________ Ext: _______
Birth Date: ___/___/____ Age: _______ SS #: ___-____-_____ Driver's License #: _______________ State: _______
Sex: ☐ Male ☐ Female   Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed ☐ Minor
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired   Employer/Occupation: _______________

PERMISSION TO RELEASE INFORMATION

I give permission to **Pearlfection Dentistry** to give Clinical, Personal and Financial information regarding my treatment to:
Name: _______________ Relationship: _______________ Phone: _______________
Name: _______________ Relationship: _______________ Phone: _______________

INSURANCE INFORMATION

Primary Insurance:
Name of Insured: _______________ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SS #: _____-_____-______ Insured Birth Date: ____/____/____ Insured Employer: _______________
Insurance Company: _______________ Subscriber ID #: _______________ Group #: _______________

Secondary Insurance:
Name of Insured: _______________ Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured SS #: _____-______-_____ Insured Birth Date: ____/____/____ Insured Employer: _______________
Insurance Company: _______________ Subscriber ID #: _______________ Group #: _______________

I certify that I and/or my dependent(s) have insurance coverage with the company/ies stated above and assign directly to Pearlfection doctors all insurance benefits, if any, otherwise payable to me for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent or Guardian: _______________ Date: _______________

MEDICAL HISTORY

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following:

Patient First Name: ________________________________ Last Name: ________________________________ Middle Initial: __________

PHYSICIAN

Physician Name/Location: ____ Date of last visit: ________________

HEALTH CONDITIONS - Please check the conditions you have or have had & provide the date of when you had the condition.

☐Abnormal Bleeding	☐Cold sores	☐Hepatitis	☐Mitral valve prolapse
☐ AIDS	☐Diabetes- AIC Level_	☐Herpes	☐Neurologic condition
☐Alcoholism	☐Drug dependency	☐High blood pressure	☐Pacemaker
☐Allergies	☐Emotional condition	☐High cholesterol	☐Rheumatic fever
☐Anemia	☐Epilepsy	☐HIV positive	☐Rheumatic heart disease
☐Arthritis	☐Fainting spells	☐Hives	☐Seizures
☐Artificial joint	☐Frequent headaches	☐Kidney disease	☐ Sinus trouble
☐Artificial valve	☐Hayfever	☐Liver disease	☐Stroke
☐Asthma	☐Heart ailment	☐Low blood pressure	☐ Tuberculosis
☐Blood disorders	☐Heart angina	☐Low cholesterol	☐Tumor
☐Blood transfusion	☐Heart defect	☐Lung problems	
☐Cancer	☐Heart murmur	☐Migraine headaches	

Date/details of any conditions you have experienced:

____

____

____

HEALTH CONDITION QUESTIONS- Please answer the following questions based on your health

Do you smoke or use chewing tobacco? ☐ Yes ☐No Joint replacement?☐ Yes ☐No Where/When? _______________

Has anyone told you that you snore?☐Yes ☐No Have you ever been told that you stop breathing during sleep?☐Yes ☐No

Have you been hospitalized in the last year? ☐Yes ☐No If so, what is the reason?__________________________________

MEDICAL LIST- Please list your current medications & the reason.

____ ____

____ ____

____ ____

____ ____

____ ____

ALLERGY LIST - Please list any allergies (latex, medication, etc.)

____ ____

____ ____

WOMAN - Please answer the following questions.

Are you pregnant?☐ Yes ☐ No Expected delivery date? Are you taking Birth Control or Hormones? ☐Yes ☐ No

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

Signature of Patient, Parent or Guardian: ____ Date: __________________

DENTAL HISTORY

Please provide us with details on your dental history and your thoughts on your smile.

Patient First Name: ________________________________ Last Name: ________________________________ Middle Initial: ______

DENTAL CONDITIONS- Please answer & mark any conditions you have/have had & provide the date of when you had the condition.

Name/Location of previous dentist: ____Date of last dental visit: ________________

Are you apprehensive about dental treatment?	☐ Yes	☐ No
Have you had problems with previous dental treatment?	☐ Yes	☐ No
Do you gag easily?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No
Do you chew on only one side of your mouth?	☐ Yes	☐ No
Do your gums bleed easily?	☐ Yes	☐ No
Are your teeth sensitive (to hot or colds)?	☐ Yes	☐ No
Do you clench or grind your jaws & do they feel tired?	☐ Yes	☐ No
Do you have a temporomandibular (jaw) disorder (TMJ)?	☐ Yes	☐ No
Do you use cigarette, cigar, pipe or chewing tobacco?	☐ Yes	☐ No
	☐ Yes	☐ No

How often do you brush?________________________________

How often do you floss?_________________________________

PERSONALIZED SMILE EVALUATION

Please take a moment to look at your teeth and gums carefully and then answer the following questions.
Your answers are personal and held in strict confidence.

1. On a scale 1-10, how do you feel about your teeth and smile? (1-worst, 10-best)________________________________

2. Are your teeth crooked or crowded and is that a concern? Please comment.________________________________

____

____

3. Do you have any spaces between your teeth that bother you?________________________________

____

____

4. Do you like the color of your teeth? Please comment.________________________________

____

____

5. Do you like the shape of your teeth? Please comment. ________________________________

____

____

6. What would you like to change about the appearance of your smile?________________________________

____

____

7. Have you ever considered how you might feel with a brighter smile? Please comment.

____

____

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

Signature of Patient, Parent or Guardian: ____ Date: __________________

FINANCIAL POLICY

Thank you for choosing PearlFection Dentistry. Let us take a moment to review the financial policy of our practice.

Payment Options: We accept cash, checks, all major credit cards and Care Credit.

PearlFection Dentistry requires payment at the beginning of your treatment. A financial deposit of the lesser of 50% or $200 is required to reserve your treatment appointment.

A fee of $50 is charged for patients who miss/cancel an appointment with a hygienist or general doctor without 48-hour notice and the deposit is forfeited for missed/cancelled appointments with specialists, without 48-hour notice.

PearlFection charges $50 for any accounts sent to an outside collections service.

A credit card is required to be kept on file. By signing below, you authorize PearlFection to charge that card, without further notification, any balance less than or equal to $100 and the full amount of any check sent to the patient by an insurance company. Patients will be invoiced for balances larger than $100.

Non-Assignment of Benefits: Certain Insurance Companies send checks directly to patients. When we suspect an insurance company may send checks to the patient, we ask the patient to select which payment option they agree to. This is not applicable to most insurance carriers. (Certain Delta and BCBS plans do this) ◻ Not Applicable

◻ Option 1 - I agree to pay 100% of my treatment in advance and receive a discount of 3% for treatment, other than routine cleanings. I understand the reimbursement check from my insurance company will most likely come to me and I am free to cash it. If a check is sent to PearlFection, it will be cashed, and a credit will be issued on my account. Upon my request any credit on my account will be mailed to me or applied back to my credit card

◻ Option 2 – I would like to pay only my estimated patient portion at time of treatment and wait to pay the remaining balance until my insurance processes my claim (but never longer than 6 weeks from date of treatment). I understand that the reimbursement check will likely be sent to me. I understand that if I choose this option my credit card on file will be charged for the full amount of my unpaid balance when Pearlfection is notified of a check being issued or after the 6th weeks from the date of my treatment, regardless of whether I have been reimbursed by my insurance company.

In order for PearlFection to assist me in getting reimbursed by my insurance, it is my responsibility to provide timely information regarding explanation of benefits, insurance denials, secondary insurance, medical insurance and anything insurance related to my claim. PearlFection will make reasonable efforts to submit my claims accurately and timely but accepts no responsibility for timely payment by insurance and after 6 weeks, whether my insurance company issues reimbursement, I am obligated for payment in full and I authorize PearlFection to use my credit card on file to pay my remaining balance.

The last 4 digits of the credit card I would like to use to pay my balance are __________. If no card number is given or if the card is unable to process the balance, I authorize PearlFection to use any cards previously provided to the practice.

By signing below, I acknowledge my understanding that anything related to insurance payments that were shown to me are estimates and is not a guarantee of reimbursement. It is understood that PearlFection does not guarantee that my insurance will pay for any of my treatment. **We do our best to estimate what your insurance will pay, but regardless if your insurance pays some, all, or none of the costs, you are 100% responsible for the full cost.**

We require assignment of benefit payments from insurance companies. The outlined estimate we provide is based on limited information obtained from your insurance company. You can request a predetermination of benefits be submitted prior to any work being done. Predeterminations do not guarantee benefits will be paid.

AUTHORIZATION AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with ______________________and assign directly to Pearlfection Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. Pearlfection may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Patient/Guardian Signature: ______________________________Date: ____________

Print Name: ______________________________Relationship to Patient: ____________

PATIENT REGISTRATION

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.

This Notice of Privacy Practices 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 to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In

addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, (301)663-555 for further information about the complaint process.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

____
Patient's Signature/Guardian's Signature

____
PRINT Patient's Name

____
PRINT Guardian's Name

____
DATE

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.
- ☐ Communications barrier prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please Specify) ______________________________