RIVERSIDE FAMILY DENTAL

Adult Registration Form

Patient's Name _____ _____ _____
Last First Initial

Marital Status (circle one): Single Married Minor Widowed

Sex: ☐ Male ☐ Female Date of Birth ____/____/_____ Age:____ Social Security # _____-_____-_____

Mailing Address_____ Home Phone**:** (____)_____-_____
City _____ State_____ Zip_____ Work Phone: (____)_____-_____
E-mail Address: _____ Cell Phone: (____)_____-_____
Employed By: _____ Occupation: _____

Spouse's Name _____ _____ _____
Last First Initial
Sex: ☐ Male ☐ Female Date of Birth ____/____/_____ Age:____ Social Security # _____-_____-_____

Mailing Address: _____ Home Phone: (____)_____-_____
City _____ State_____ Zip_____ Work Phone: (____)_____-_____
E-mail address: _____ Cell Phone: (____)_____-_____
Employed By: _____ Occupation: _____

Who is Responsible for this Account? _____

How would you prefer we contact you to confirm your appointments: ☐ Phone call ☐ Email ☐ Either

How did you hear about our office? ☐ Hansen Phone Book ☐ Location ☐ Website ☐ Social Media

☐ Former patient of Dr. Grimm ☐ Friend/Family_____ ☐ Other_____

Does the Patient have Dental Insurance Coverage? ☐Yes ☐ No Insurance Co._____

Who is the policy holder? ☐ Myself ☐ My spouse Insurance ID#_____

Someone to Notify in Case of Emergency, Not Living With You:

_____(___)_____
Name Phone Number

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care including the possible use of diagnostic x-rays, local anesthetic and fluoride.
I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I authorize release of any information concerning my health care, advice and treatment to another dentist or healthcare professional.
I hereby authorize payment of insurance benefits directly to the dentist or dental group otherwise payable to me.
I understand my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
I attest to the accuracy of the information on this page.

PATIENT SIGNATURE _____ DATE _____/_____/_____

HIPPA Release Form

PRIVACY OF PROTECTION HEALTH INFORMATION

Federal and state law require us to maintain the privacy of your health information and to give you this notice about our privacy practices, our legal duties, and your rights concerning Protected Health Information (PHI). This notice took effect April 14, 2003. We reserve the right to change our privacy practices and the terms of this Notice at any time, law permitting. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information in the following circumstances:

*To a dentist, physician or other healthcare provider in our health care team providing treatment to you.
*To obtain payment services we provide to you.
*In connection with our healthcare operations, including quality assessment and improvement activities, evaluating practitioner and provider competence, conducting training and educational programs, accreditation, certification, licensing or credentialing activities.
*When you give us written authorization to use your health information or to disclose it to anyone for any purpose other than treatment, payment and healthcare operations. You may revoke this authorization in writing at any time.
*Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.
*We will disclose information to you, the patient. With your permission, we may disclose your health information to a family member, friend, or other person, to obtain help with your healthcare and payment for your care.
*To notify, or assist in notifying a family member, your personal representative or another person responsible for your care, of pertinent issues, such as your location, your general condition, illness, or death. If you are present, we will provide you an opportunity to object to such uses or disclosures.
*We will use or disclose your health information to provide you with appointment reminders such as voicemail messages, postcards or letters.
*Riverside Family Dental may use or disclose PHI for reasons other than those listed. Examples of such uses include: consultation with other professionals, patient recruitment, public health activities, health oversight activities and worker's compensation.

WE ARE REQUIRED BY LAW TO DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING CIRCUMSTANCES:

Abuse or Neglect

We are required by law to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes, or to avert a threat to the health or safety of yourself or others.

Government Agencies

Under certain circumstances, we are required by law to disclose to military authorities the health information of Armed Forces personnel. We may disclose to authorized officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose protected health information to correctional institutions or law enforcement officials having custody of patients under certain circumstances.

WE WILL NOT DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING CIRCUMSTANCES:

Research

We will not use or disclose information about you for research purposes without your prior permission.

Marketing Health Related Services

We will not use your health information for marketing communications without your written authorization.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION

You have the right to:

*Expect that PHI will be treated confidentially within the dental care team.
*Receive copies of your PHI. To obtain access to your health information, you may use an authorization form or send a letter to the contact information at the end of this Notice. We will charge a reasonable, cost-based fee for expenses to make photocopies, radiograph copies, facsimiles or other formats of PHI.
*Receive a list describing how we or our business associates disclose your PHI for purposes, other than treatment, payment, and healthcare operations, since April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to the additional requests.
*Request that we place additional restrictions on our use or disclosure of PHI. Although we are not required to agree to these additional restrictions, if we do, we will abide by our agreement (except in an emergency).
*Request in writing that we amend your PHI. We may deny your request under certain circumstances.
*Request that we send PHI to you at an alternate address, if we can provide it in the format you requested. To make a request, you may contact our office at 319-648-3900.

QUESTIONS AND COMPLAINTS

You may contact us using the information at the end of this Notice if:

*You would like more information about our privacy practices.
*You wish to comment on a request you made to amend or restrict the use or disclosure of your health information.
*You disagree with a decision we have made about access to your health information.
*You feel that we may have violated your privacy rights.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Service.

CONTACT INFORMATION

Riverside Family Dental
380 E. Hickory Street
Riverside, IA 52327
Telephone: 319-648-3900

Signature (Parent/Legal Guardian)_____Date_____

Adult Health History

Name _____ Date _____

Date of last medical exam or physical: _____

Are you currently receiving medical care? No Yes- If yes, nature of care: _____

Please list all the names of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

Have you ever been hospitalized or had surgery? No Yes
If yes, reason(s): _____
_____
_____

Circle yes or no if you have or have had in the past any of these conditions.
Your answers are for our records only and will be confidential.

Abnormal Bleeding	No	Yes	Heart Attack	No	Yes, When:
Anemia or Blood Disease	No	Yes	Heart Valve Replacement/Repair	No	Yes, When:
Sleep Apnea	No	Yes	Heart Bypass/Surgery	No	Yes, When:
Intellectual Disability	No	Yes	Organ Transplant	No	Yes, Type:
Alzheimer's or Dementia	No	Yes	Tumor or Cancer	No	Yes, Type: Treatment: Chemo. Radiation
Thyroid Disorder	No	Yes	Epilepsy/Seizures	No	Yes, Type:
Parkinson's Disease	No	Yes	Auto- Immune Disease	No	Yes, Type:
Multiple Sclerosis	No	Yes	Joint Replacement Type:	No	Yes When:
Glaucoma	No	Yes	Stroke	No	Yes, When:
Kidney Disease	No	Yes	Liver Disease	No	Yes
Asthma	No	Yes	Hepatitis	No	Yes, Type: A B C
Emphysema or COPD	No	Yes	Diabetes	No	Yes, Type: I II
Hypertension (high blood pressure)	No	Yes	Radiation to head/neck besides dental x-rays	No	Yes
Fainting or Dizzy Spells	No	Yes	Drug or Alcohol abuse/	No	Yes
Hearing Impairment	No	Yes	Eating Disorder	No	Yes: Anorexia Bulimia
Abnormal Heart Condition	No	Yes	HIV Infection/AIDS	No	Yes
Angina or Chest Pain	No	Yes	Mental Health Disorder	No	Yes
Heartburn/GERD/Acid Reflux	No	Yes	Currently Taking Birth Control Pills	No	Yes
Pacemaker or Defibrillator	No	Yes	Currently pregnant or nursing	No	Yes, Due Date:

Do you use tobacco? No Yes- Type: cigarettes/cigars chewing tobacco pipe vaping

If yes, how much do you smoke/chew per day? _____ For how many years? _____

Do you take a blood thinner such as WARFARIN that you have your INR checked for regularly? Yes No

Are you allergic or have you had a reaction to:

a. Latex……..... No Yes
b. Penicillin …… No Yes
c. Sulfa……. No Yes
d. Aspirin ….……..…….... No Yes
e. Codeine, Valium or other sedatives……..… No Yes
f. Metals/Jewelry…… No Yes
g. Other _____

Please list any **prescription or over the counter medications, vitamins or herbal supplements** you are currently taking or supposed to be taking: Or, provide a list to be copied.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health and medication.

_____ _____ _____ _____

Patient Signature **Date** **Doctor Signature** **Date**

Updated: Initials/Date

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

Blood Pressure/Date

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____

RIVERSIDE
FAMILY DENTAL

Financial Policy

- Please check with your insurance company to verify Dr. Grimm can provide dental care under your insurance plan. We will submit to any insurance company, but if Riverside Family Dental Practice is not currently a provider for your plan, you will be responsible for all outstanding charges after insurance payment.
- You are responsible for being aware of what benefits are available with your insurance plan. We will assist you as much as possible, but if you have questions about your coverage you should consult your insurance manual or contact your insurance directly.
- Riverside Family Dental requires payment of your estimated co-payment the day you receive treatment. Your estimates are based on information your insurance company gives us which is often inadequate and may result in under or overpayment. You will be sent a statement if there is a balance due or a credit refund if there was overpayment.
- We will send in any documentation or explanation of treatment to help process your claims. If, after 90 days, the claim is not paid or additional action on your part is necessary, you will be responsible for the balance in full.
- If you do not have dental insurance the total charges will be due the day of treatment.
- We accept cash, personal checks, Master Card and Visa. If your payment is made with cash or check a 5% courtesy reduction will be given.
- Financing options from Care Credit are available to those who qualify. These plans allow monthly payments for your dentistry and may be interest free. Terms and conditions vary. Please visit carecredit.com or inquire at the practice for more information.

Children in the Office Policy

Children, unless they are receiving treatment, are not allowed in treatment rooms. For their safety and due to limited space, a child that accompanies a parent to an appointment must stay in the waiting room. Please keep this in mind when scheduling appointments if you are uncomfortable with the child unattended in the waiting room during your appointment. Thank you for your cooperation.

Cancellation Policy

Cancellations on short notice due to emergencies and last-minute developments can and do happen to all of us. However, the lack of reasonable, advanced notice (less than 24 hours) results in lost opportunities to serve others. This unproductive time is frustrating, not only to us, but to those patients whose treatment requires more immediate attention than our busy schedule allows. Therefore, if a patient fails or cancels two (2) scheduled appointments with less than 24 hours advanced notice, a broken appointment fee of $50 will be assessed. This fee must be settled prior to scheduling any future appointments. If a patient fails or re-schedules three (3) appointments without adequate notice the doctor patient relationship may be terminated.

We greatly appreciate your efforts to honor your scheduled appointments and wish to continue to provide all our patients with the highest quality of care in a timely manner.

Signature (patient/parent/legal guardian)_____ Date_____