PHYE
FAMILY DENTISTRY

NEW PATIENT REGISTRATION

Patient Information

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No: _____ Male: ☐ Female: ☐ Single: ☐ Married: ☐ Widowed: ☐ Divorced: ☐

Cell #: _____ Work #: _____ Email: _____

Are you employed? Yes: ☐ No: ☐ Student Status if over 19 (required for insurance): Full Time: ☐ Part Time: ☐ Non Student: ☐

Occupation: _____ Employer: _____ Employer Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Who may we thank for referring you to our office: _____

Emergency Contacts / Guardian(s)

Relationship to patient: Spouse: ☐ Significant Other: ☐ Friend: ☐ Guardian: ☐

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

Home #: _____ Cell #: _____ Work #: _____

Relationship to patient: Spouse: ☐ Significant Other: ☐ Friend: ☐ Guardian: ☐

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

Home #: _____ Cell #: _____ Work #: _____

Insurance Information

(All information is required to be completed in order for our office to submit insurance claims on your behalf. Incomplete, incorrect information, or an inability to verify insurance eligibility will result in fees being collected at the time of service. A valid Driver's License and Insurance Card must be presented at the time of service.)

Patient's Relationship to Subscriber: Self: ☐ Spouse: ☐ Child/Dependent: ☐

Primary Insurance: _____ Membership #: _____ Group / ID#: _____

Subscriber Name: _____ Birthdate: _____ SSN #: _____

Patient's Relationship to Subscriber: Self: ☐ Spouse: ☐ Child/Dependent: ☐

Secondary Insurance: _____ Membership #: _____ Group / ID#: _____

Subscriber Name: _____ Birthdate: _____ SSN #: _____

Consent and Acceptance

I consent to the diagnostic procedures and treatment necessary for proper dental care as prescribed by the doctor.

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____

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MEDICAL HISTORY

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

Are you under a physician's care now? Yes: ☐ No: ☐ If Yes, who?: _____

Have you ever had a serious head or neck injury? Yes: ☐ No: ☐ If Yes, explain: _____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Tetracycline
☐ Milk Products ☐ Other _____

Do you have, or have you had, any of the following?

	Yes	No
Acid Reflux	☐	☐
AIDS/HIV Positive	☐	☐
Alzheimer's Disease	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Arthritis/Gout	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joints	☐	☐
Asthma	☐	☐
Autoimmune disease	☐	☐
Bipolar Disorder	☐	☐
Blood Disease	☐	☐
Breathing Problem	☐	☐
Cancer	☐	☐
Type: _____ Year: _____		
Chemotherapy	☐	☐
Chest Pains	☐	☐
Cold Sores/Fever Blisters	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Eating Disorder	☐	☐
Endocarditis	☐	☐
Emphysema	☐	☐
Epilepsy or Seizures	☐	☐
Excessive Bleeding	☐	☐
Frequent Headaches	☐	☐
Hay Fever	☐	☐
Heart Trouble/Disease	☐	☐
Heart Attack	☐	☐
Hemophilia	☐	☐
Hepatitis A	☐	☐
Hepatitis B or C	☐	☐
High Blood Pressure	☐	☐
Hypoglycemia	☐	☐
Low Blood Pressure	☐	☐
Liver Disease	☐	☐
Mental Health Conditions	☐	☐
Osteoporosis	☐	☐
Organ Transplant	☐	☐
Pacemaker	☐	☐
Pain in Jaw Joints	☐	☐
Radiation Treatments	☐	☐
Rheumatic Fever	☐	☐
Sinus Trouble	☐	☐
Sleep Apnea	☐	☐
Snoring	☐	☐
Stomach/Intestinal Disease	☐	☐
Stroke	☐	☐
Substance Abuse	☐	☐
Thyroid Disease	☐	☐
Tonsillitis	☐	☐
Tumors or Growths	☐	☐
Ulcers	☐	☐
Vertigo	☐	☐

Do you have a neurological disorder such as?

	Yes	No
Myasthenia Gravis (MA)	☐	☐
Amyotrophic lateral sclerosis (ALS)	☐	☐
Lambert Eaton Syndrome	☐	☐

Women, are you:

	Yes	No
Pregnant	☐	☐
Trying to get pregnant	☐	☐
Nursing	☐	☐
Taking oral contraceptives	☐	☐

Do you take blood thinners such as?

	Yes	No
Aspirin	☐	☐
Eliquis	☐	☐
Xarelto	☐	☐
Vitamin E	☐	☐
Ginkgo Biloba	☐	☐
St. John's Wort	☐	☐
Ibuprofen/Motrin	☐	☐
Aleve	☐	☐
Vioxx	☐	☐
Other: _____		

Have you ever used bisphosphonates? (ie.Fosamax, Boniva) ☐ ☐

Do you have heart issues?

	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐

Other: _____

Do you use?

	Yes	No
Tobacco	☐	☐
Smokeless tobacco	☐	☐
Drugs	☐	☐

Are there any other medical conditions not listed above? Yes: ☐ No: ☐ If Yes, explain: _____

Preferred Pharmacy:

Name: _____ Phone #: _____ Location: _____

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.

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____

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HIPAA AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Last Name: _____ First: _____ MI: _____ Birthdate: _____

Section I

I authorize Phye Famliy Dentistry, PA and its representatives to use or disclose the following health/dental information in Section II as it relates to my care.

Phye Famliy Dentistry, PA may disclose the above information to the following person or persons:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I understand that the person(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section II

I give my permission to disclose my complete health/dental record but not limited to, diagnoses, test results, treatment and billing and insurance information for all conditions.

Section III

This authorization to share the above listed information is valid (choose one box below):

❑ a) From _____ to _____.

OR

❑ b) All past, present and future periods.

OR

❑ c) The date of the signature in Section IV until the following event:

_____

Section IV

I understand that I am permitted to revoke this authorization to share my health/dental data at any time and can do so by submitting a request in writing to:

Phye Famliy Dentistry, PA
401 S. Clairborne, Suite A
Olathe, Kansas 66062

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____

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FINANCIAL POLICY AGREEMENT

Our mission is to deliver the finest most cost effective Dental Care available today. Following diagnosis, the Dentist will advise you on a plan for treatment (Treatment Plan). Additionally, we will discuss with you the cost of today's visit and any future treatment.

Payment for today's visit and your future visits are due at time of treatment. We accept cash, check, Visa, MasterCard, American Express, and CareCredit Financing. We reserve the right to add a transaction fee to cover any merchant costs above 3% of the transaction.

Insurance

In an effort to make general dentistry more affordable for you, we participate in some PPO (Preferred Provider Organization) type programs. PPO's are preferred providers which entitle the participant to contracted reduced fees according to their plan fee schedules. Many plans pay fixed allowances for certain procedures while others pay a certain percentage of the charge. "Reasonable and Customary Fees" are determined by your insurance carrier and may vary greatly between carriers. **It is YOUR responsibility** to pay any deductible, co-insurance or any other balance not covered by your insurance. Please be aware that some, and perhaps all, of the services provided may be non-covered services, and not considered reasonable and necessary by your insurance carrier. You are financially responsible for any and all charges not paid by your insurance.

Your insurance policy is a contract between you and your insurance company. The estimate provided by our office is considered as a guideline until final insurance payment, if any, is received and the patient's account has been paid in full. **We make no guarantee of the insurance payment as estimated.**

As a courtesy, we will file insurance claims for you; however, this does not substitute for payment owed by you. Claims are submitted promptly after treatment is rendered, and if not paid by the patient's insurance company by the **60th day** after treatment is rendered, **the total outstanding account balance will be billed directly to the patient.**

Finance Charges, Fees and Collections

There will be a finance charge applied to all accounts over 90 days regardless of any financial arrangements that have been made. Past due accounts may be referred to collections if the balance is not paid in full in the 90 day time frame, unless financial arrangements have been made and the terms adhered to.

You acknowledge and agree, by your signature below, that our representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone, at any number associated with your account, including wireless telephone numbers, which could result in charges to you. Contact may include sending text messages, or emails, and using any email address you provide to us. Methods of contact may include prerecorded/artificial voice messages and/or use of an automatic dialing device as applicable. All fees incurred by the practice in effort to collect a patient's debt, including all attorney fees, may be recovered by the practice.

If the patient is a minor or dependent, the person/parent/guardian that brings the patient for care is responsible for all co-pays, co-insurance, and deductibles. Our practice is not part of any divorce decrees.

Appointment times are reserved for your specific care and treatment. There will be a fee charge for cancellations made with less than a 24-hour notice, as well as not showing for your appointment.

Acknowledgment and Agreement

By signing below, I acknowledge that I have read, understand and agree to the terms of this Financial Policy Agreement. I understand that I am financially responsible for all charges whether or not my insurance covers them. I hereby assign my insurance benefits be paid to Phye Family Dentistry, PA and authorize the Dentist to release to my insurance carrier(s), any and all information required to process any claim(s).

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Phye Family Dentistry, PA is required by law to maintain the privacy of protected health information (PHI), to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/11/2002, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your care or Payment for Your care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the

health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI 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 disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 with the U.S. Department of Health and Human Services.

Our Privacy Official: Adrian Gomez, DDS
Telephone: 913) 782-2231 Fax: (913) 782-2246
Address: 401 S. Clairborne, Suite A, Olathe, Kansas 66062
E-mail: frontdesk@phyedentistry.com

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Last Name: _____ First Name: _____ MI: _____ Birthdate: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices made available to me in the patient waiting area. I understand that I am giving my permission to use and disclose my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

It is important for us to honor your confidentiality. Please check your preferences below.

☐ You may discuss my dental/account information **only** with me.

☐ I give my permission to discuss my dental/account information with the following people:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ Yes or ☐ No You may leave me a message with details on my voicemail at:

Home #: _____ Cell #: _____ Work #: _____

Patient (or Parent/Guardian) Signature: _____ Date: _____

Print Name: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices. However, acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other: _____