GLACIER LAKE DENTAL

Patient Registration

Patient Information

Name: _____ (_____) Social Security #: _____
Last Name First Name Preferred Name

Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ E-mail: _____

Sex: Male ☐ Female ☐ Birthdate: _____ Age: _____ Single: **o** Married: **o** Widowed: **o** Separated: **o** Divorced: **o**

Employer: _____ Occupation: _____

Work Address: _____ _____ _____ _____ Phone: _____
Street City State Zip

Appointment Time Preference:

Part Time Student: **o** No Preference: **o**
Prefer AM: **o**

Name of School (If Patient Is A Student): _____ Full Time Student: **o** Prefer PM: **o**

Emergency Contact: _____ Phone: _____

How did you hear about us or who may we thank for referring you? _____

Primary Dental Insurance

Policy Holder: _____ _____ _____ _____
Last Name First Name **Date of Birth** Relationship to Patient

Address (if different from patient): _____ _____ _____ _____
Street City State Zip

Policy Holder's Employer: _____ Occupation: _____

Business Address: _____ _____ _____ Business Phone: _____
City State Zip

Insurance Company: _____ **SS or ID#:** _____ **Group #:** _____

Additional family members under this plan: _____

Additional Dental Insurance

Policy Holder: _____ _____ _____ _____
Last Name First Name **Date of Birth** Relationship to Patient:

Address (if different from patient): _____ _____ _____ _____
Street City State Zip

Policy Holder's Employer: _____ Occupation: _____

Business Address: _____ _____ _____ Business Phone: _____
City State Zip

Insurance Company: _____ **ID/SS #:** _____ Group #: _____

Additional family members under this plan: _____

I certify that the above information is true and correct to the best of my knowledge.
I agree to notify Glacier Lake Dental of any changes in the above information and/or my health status.

X _____ _____
Signature of Patient, Parent or Guardian Date

Patient Health History

Patient's Name: _____ **Date of Birth:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Any health problems that you have or medications that you take can have an important effect on the dentistry you will receive. Thank you for completing this form.

Reason for today's visit: _____ Date of last dental care: _____

Former Dentist: _____ Date of last dental x-rays: _____

How often do you brush? _____ How often do you floss? _____

Have you ever been diagnosed with or treated for gum disease? ¨ Yes ¨ No If yes, when: _____

Check if you have, or have you ever had, any of the following:

Bleeding Gums	Food Collection between Teeth	Sensitivity when Biting	Broken Fillings
Breath Malodor	Grinding Teeth	Sensitivity to Cold	Sores or Growths in Your Mouth
Clicking or Popping of Jaw	Jaw Pain	Sensitivity to Heat	
Dry Mouth	Loose Teeth	Sensitivity to Sweets	

If you had a magic wand, how would you change the appearance of your teeth? _____

	Yes	No	If Yes, explain:
Are you under a physician's care now?			
Have you ever been hospitalized or had a major operation?			
Have you ever had a serious head or neck injury?			
Are you taking any medications, pills or drugs?			
Do you take, or have you taken, Phen-Fen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			

Are you allergic to any of the following?	Yes	No
Aspirin		
Penicillin		
Codeine		
Acrylic		
Metal		
Latex		
Local Anesthetics		
Other allergies:		

Women - Are you:	Yes	No
Pregnant/Trying to get pregnant?		
Nursing?		
Taking oral contraceptives?		

Any family history of:	Yes	No
Heart disease?		
Diabetes?		
High blood pressure?		

Check if you have, or have you ever had, any of the following:

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Disorder	Hay Fever	Liver Disease	Sinus Trouble
Angina	Convulsions	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Cortisone Medicine	Heart Murmur	Lung Disease	Stomach/Intestinal
Artificial Heart Valve	Diabetes	Heart Pace Maker	Mitral Valve Prolapse	Disease
Artificial Joint	Drug Addiction	Heart Trouble/Disease	Pain in Jaw Joints	Stroke
Asthma	Easily Winded	Hemophilia	Parathyroid Disease	Swelling of Limbs
Blood Disease	Emphysema	Hepatitis A	Psychiatric Care	Thyroid Disease
Blood Transfusion	Epilepsy or Seizures	Hepatitis B or C	Radiation Treatments	Tonsillitis
Breathing Problem	Excessive Bleeding	Herpes	Recent Weight Loss	Tuberculosis
Bruise Easily	Excessive Thirst	High Blood Pressure	Renal Dialysis	Tumors or Growths
Cancer	Fainting Spells/Dizziness	Hives or Rash	Rheumatic Fever	Ulcers
Chemotherapy	Frequent Cough	Hypoglycemia	Rheumatism	Venereal Disease
Back Problems	Frequent Diarrhea	***Fever, Prolonged***	***Lupus***	Yellow Jaundice
	Circulatory Problem			***Night Sweats***

Any serious illness not listed above? Yes No Explain: _____

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 medical status.

X _____ _____

Signature of Patient, Parent or Guardian Date

GLACIER LAKE DENTAL

Financial Policy

Thank you for choosing Glacier Lake Dental for your dental care! We are committed to your successful treatment. Please read our office policies carefully and sign at the bottom to proceed with your appointment.

Payment

Payment for our services is due at the time of your visit. We accept cash, personal checks, and major credit cards. For payments exceeding $300, we also offer interest-free financing options through CareCredit, a third party healthcare financing organization.

Insurance

If you have insurance coverage, we can process the insurance claim for you, and give you an estimate for the patient portion of your bill. This portion is due at the time of service. If we do not receive payment from your insurance company within 45 days, or if the insurance coverage is less than we estimated, we will send you a bill for the outstanding amount. If we overestimated the patient portion, we will promptly send you a check for the amount you overpaid.

Late Payments

In the event your account becomes past due, we will assess a late charge equal to 1.5% per month of your outstanding account balance. If your account becomes overdue by more than 90 days, it will be referred to an outside collection agency. You will then be responsible for the collection costs incurred by Glacier Lake Dental in collecting the payment.

Returned Checks / Insufficient Funds

Checks that are returned as a result of insufficient funds or an account being closed or suspended, will be assessed a $15 processing fee.

Correspondence

Glacier Lake Dental (or a person or office acting on our behalf) may contact me via mail, phone, or e-mail to remind me of my appointment, discuss my treatment, and/or my account. Reminders that do not disclose financial or specific medical information may be sent in the form of an open postcard. Correspondence that contains financial or specific medical information will be sent in a closed envelope.

Appointment Cancellation / Missed Appointment

We charge a **$50 cancellation/failed appointment fee, unless given at least 24 hours notice,** so we can offer the appointment time to another patient.

I have read and understand these policies:

X_____ _____

Signature of Patient or Legal Representative **Date**

Patient Name (Please Print): _____

Tracy L. Grasdal, DDS
10450 185th Street West • Lakeville, MN 55044 • (952) 435-9888 • fax (952) 435-9820
Smiles@GlacierLakeDental.com • www.GlacierLakeDental.com

GLACIER LAKE DENTAL, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Date of Birth: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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

Contact Person:	**Glacier Lake Dental - Practice Coordinator**
Telephone:	**(952) 435-9888**
Fax:	**(952) 435-9820**
E-mail:	**smiles@glacierlakedental.com**
Address:	**10450 185th Street W., Suite 500, Lakeville, MN 55044**

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

SIGNATURE

I, X _____ **acknowledge** that I

1. have received a copy of this office's Notice of Privacy Practices, and:
2. have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices.

I understand that, by signing the line below, I am giving my **consent** to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: X_____ ***Date:*** X:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.15 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Practice Coordinator

Telephone: (952) 435-9888 Fax: (952) 435-9820

E-mail: smiles@glacierlakedental.com

Address: Glacier Lake Dental, P.A., 10450 185th Street W., Suite 500, Lakeville, MN 55044