PATIENT INFORMATION

PLEASE PRINT THE FOLLOWING INFORMATION

PATIENT _____ **AGE**_____

O CHILD O SIMGLE O MARRIED O DIVORCED O WIDOWED O SEPARATED

HOME ADDRESS _____

CITY_____ **STATE** _____ **ZIP**_____

HOME PHONE_____

IP PATIENT IS A MINOR, NAME OF RESPONSIBLE PARENT _____

PATIENT OR PARENT EMPLOYED BY _____

BUS PHONE_____

BUS ADDRESS_____ **OCCUPATION**_____

NAME OF SPOUSE_____ **OCCUPATION**_____

BUS. ADDRESS_____ **BUS PHONE**_____

BIRTHDATE _____ **SOC SEC #** _____

DENTAL INS. PLAN _____

REFERRED BY _____ **PHYSICIAN** _____

Health Questionnaire

1. **What is your present dental problem**?_____

(a) **Date of last exam**_____

(b) **What services were done**_____

(c) **When x-rays last taken**_____

(d) Have you ever had periodontal (gum) treatment? ——————————— NO YES
(e) Have you ever worn braces? ——————————————————————— NO YES
(t) Are your teeth sensitive to hot or cold? _____NO YES
(g) Do your gums bleed easily? ——————————————————————— NO YES

2 Have you had an unusual reaction to any drugs or medicines? ——————— NO YES
To What? i.e. Penicillin _____
3 Is your physician treating you now? _____ NO YES
4. Are you taking any medicines or tablets? ——————————————————— NO YES
What? _____
5 Have you taken cortisone or steroids? _____ NO YES
6 Have you any allergy? _____ NO YES
7 Are you a bleeder or bruise easily? _____ NO YES
8. Do you faint easily?_____ NO YES
9. Have you heart disease or murmur? _____ NO YES
10. If a female, are your pregnant7 _____ NO YES
11. Do you smoke? _____ NO YES

12 **Do you have or have you had? Circle**.

Heart trouble Diabetes Blood disorders
High blood pressure Epilepsy Anemia
Rheumatic fever Thyroid trouble Hepatitis
Kidney trouble Tuberculosis Venereal disease
Liver trouble Asthma HIV Stroke
Pacemaker Sinus trouble Any others _____

13. **Before treatment can be rendered, adequate radiographs of the teeth and mouth may be taken.**

OFFICE POLICY

a) Payment for professional services Is required on the day treatment Is rendered.
b) Your appointment time is reserved especially for you, so there must be a charge for appointments not cancelled 24 hrs.in advance.

This is to certify that the above information I have given is correct and current and I agree to accept full responsibility for the payment of all fees associated with the examination and/or treatment

Patient (Parent) _____ Date_____

OUR FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to your treatment being successful. Please understand that the payment of your fees, and the keeping of your appointments, is an integral part of your relationship with us. Therefore, to avoid any misunderstandings, or miscommunications, the following is a statement of our financial policy. We ask that you read it carefully, and sign and acknowledge it before commencing with treatment.

PAYMENTS

We accept cash, checks, and credit cards (Visa, MC, and Discover). On extensive treatments we also can provide financing with dental healthcare finance company. We request that payment be made at the time of your office visit when treatment is rendered. For those patients that have insurance, as a courtesy to you, we will wait for your insurance to pay its <u>estimated</u> share. We cannot be responsible if your company chooses not to pay, for whatever reason, the amount we have estimated. We ask that you pay any deductible and co-payment at the time of treatment. Also, we cannot properly bill your insurance company unless you give us correct and current insurance information. If your account is not paid in full by your insurance company within 30 days, you will then be billed for the balance. Appointments must be cancelled 24 hours in advance, otherwise, a charge will be assessed.

ABOUT YOUR INSURANCE

Your insurance policy is a contract between you and your insurance company. You are responsible to know the provisions of your policy. As your dental care provider, we perform the care we feel is necessary and correct, and has been agreed upon between the doctor and the patient. In no way can we let an insurance company dictate what is proper dental care. We are involved with hundreds of insurance companies, and thousands of patients, and cannot know the details of each individual policy, which can vary from employer to employer. We will try our best to be helpful, but we cannot take the responsibility of interpreting and educating patients about their policies. We will, however, fill out all claim forms for you, and will wait for your estimated share for a reasonable period of time. The only exception to that are Assistance type insurance plans. Thank you for your cooperation and understanding. An informed patient is our best asset, so together we will have a successful result.

I have read and understand the above financial policy statement of Hagen Dental, and am financially responsible for payment of services to Dr. Ronald M. Hagen.

___/ ___/ _____ _____

Date **Patient's signature**

HIPAA PRIVACY FORM 1

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.

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 tow 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 UB a letter to the address at the end of this Notice. If you request copies, we will charge you $.2.00 for each page. $15.00 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.

tf you are concerned that we may have violated your privacy rights, or yon 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: Dr. Ronald M. Hagen_____

Telephone: 305-667-4410_____ **Fax: 305-667-8492**_____

E-mail: rmhagendds@bellsouth.net_____

Address: 8257 S. Dixie Hwy., Miami, FL 33143_____