PATIENT REGISTRATION

Patient

First Name:_____ Last Name:_____ Middle Initial:_____

Patient Is: Policy Holder Preferred Name:_____
Responsible Party

Patient Information-Section 1

Address:_____ Address 2:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date:_____ Age:_____ Social Sec:_____ Driver's Lic:_____

Please tell us how you heard about our office:

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Ext:_____ Cell:_____

Birth Date:_____ Social Security:_____ Drivers Lic:_____

Responsible Party is also a Policy Holder for Patient **Primary Ins. Policy Holder** **Secondary Ins. Policy Holder**

Section 2

We invite you to participate in our online system. Features include: Requesting online appointments, Appointment Reminders, Confirming Appointments via Email, Referrals, and Satisfaction Surveys.

E-Mail_____ Opt In to Email: Y/N

Opt In to receive Text Messages: Y/N

Section 3

Emergency Contact:_____
Relationship:_____
Phone:_____
Physician:_____

Primary Insurance Information-Section 4

Name Insured:_____ Relationship to Patient: Self Spouse Child
Insured Social Sec.:_____ Insured Birth Date:_____
Employer:_____ Insurance Company:_____
Address:_____ Address:_____
City, State, Zip:_____ City, State, Zip:_____

Secondary Insurance Information

Name Insured:_____ Relationship to Patient: Self Spouse Child
Insured Social Sec.:_____ Insured Birth Date:_____
Employer:_____ Insurance Company:_____
Address:_____ Address:_____
City, State, Zip:_____ City, State, Zip:_____

Palaisa Orthodontics

MEDICAL HISTORY

PATIENT NAME_____ BIRTH DATE_____

Although dental personnel 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 questions.

Who is your primary care physician? _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:_____

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

Are you taking any medications, pills, or drugs? Yes No If yes, please explain:_____

Do you take, or have taken, Phen-Phen or Redux? Yes No _____

Are you on a special Diet? Yes No _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you take, or have taken, any Bisphosphonates which Include-(Actonel, Didronel, Skelid, Fosamax, Aredia, or Zometa)? Yes No

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:_____

Do you have, or have you had, any of the following? Please circle Y or N for each.

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain:_____

Comments:

_____

_____

_____

_____

_____

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.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE_____

Consent/ Authorization / Acknowledgement

Clinical

1. I authorize Dr. Jackie Palaisa, referred to as "practice" hereafter, to take necessary radiographs, study models, photos, and other diagnostic aids as needed to make thorough diagnosis.
2. I authorize this practice to perform all recommended treatment and agreed upon treatment. I also authorize the use of anesthetics sedatives and other medication (as needed) and am fully aware that using anesthetic agents involves certain risks.

Financial

3. I am responsible for payment for all services rendered on my behalf and my dependents. I have been informed that payment is due when services are rendered. Should my account become delinquent, I will assume all additional collection costs and legal fees.
4. A $50 Broken Appointment Fee may be charged to my account for all broken and/ or last minute cancellations. I am aware that to hold down operating costs, 24 hours notice of cancellation is required.

Insurance

5. I authorize this practice to release to staff, health care service planes, insurance companies, Self-insurers, or their representatives, any and all information, records, and radiographs about my medical history, services rendered, and treatment necessary.
6. I authorize this practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed a "signature on file" and assign to this practice the insurance benefits providing assignment is accepted. I understand that I am responsible for payment regardless of the coverage provided.
7. I understand I am responsible for the deductible, co-payment and excess over maximum the day of services.

Health Insurance Portability and Accountability Act 1996:
HIPPA: Acknowledgement of Receipt of Notice of Privacy Practices:
(You may refuse to sign this Acknowledgement)

8. I have received a copy of this practice's Notice of Privacy Practices.

HIPPA: Consent for Use and Disclosure of Health Information:

(Notice of Privacy Practices: You have the right to read the practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices 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. Please read this Notice prior to signing this consent. This practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time by contacting Jackie Palaisa (contact person) at 301-689-9111, 151 Bishop Murphy Drive, Frostburg, Maryland 21532, 301-687-8011 (fax). You have the right to revoke this Consent for use and Disclosure of health Information at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment in your behalf or that of you dependents if this Consent is revoked.)

9. I have had the opportunity to review and obtain copy of this practice's Notice of privacy Practices. I hereby authorize as indicated by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operations.

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgement. I have been provided with the opportunity to ask questions and obtain further clarification.

Signature Date

Circle One: Adult Patient Parent/Guardian Personal Representative

If signature provided represents the patient's guardian or "personal representative", please complete the following:

Patient Name DOB Patient's Signature Date

Please list the names of individual you permit to disclose your protected health information

1.
2
3.

Please advise us your preferred means of communication

_____ You may contact me at work
_____ You may **not** contact me at work
_____ You may **not** contact me at home or leave message
_____ You may email me over unsecured network
_____ List your other preference

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect January 15, 2008, 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 applicable law permits the changes. 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 DICLOSURES OF HEALTH INFORMATION

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

Treatment: We may use your health care information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating pracitioner and provider performances, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence of qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health care information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of our incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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, xrays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of you location and general condition.

Appointment and Service Reminders: We may use or disclose your health information to provide you with reminders of appointments or services offered (such as voicemail, text messages, email, postcards, letters, or newsletters).

Disaster Reminders: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activated, including disease and vital statistic reporting, FDA oversight, and to employers regarding work related illness or injury.
- To report adult abuse, neglect, or domestic violence
- To health oversight agencies
- In response to court and administrative orders and other lawful processes
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our Premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person.
- To coroners, medical examiners, and funeral directors.
- To an organ procurement organization

- To avert a serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activitics
- To correctional institutions regarding inmates
- As authorized by stat worker's compensation laws.

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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying cost, and postage. 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 may—but are not required to—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 more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosure for treatment, payment, health care operations, as authorized by you, and for certain other activities. 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. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request. We are not required to agree to the alternative communication, but if we do agree in writing, we will abide by our agreement.

Amendment: You have the right ot request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request in certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us using the information listed at the end of this notice.

If you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a request you made to amend or restrict the use of disclosure of your health information was incorrectly
- We should communicate with you by alternative means or at alternative locations

You may contact us using the information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you 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. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

Dental Office Contact: **HIPPA Compliance Officer**
Address: **151 Bishop Murphy Drive**
City, State, Zip: **Frostburg, MD 21532**
Telephone: **301-689-6780**
Fax: **301-687-8011**