Shaia Dental Care

HIPAA PRIVACY AUTHORIZATION AND RELEASE

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) ENACTED ON APRIL 13, 2003 BY THE FEDERAL GOVERNMENT, REQUIRED HEALTH CARE PROVIDERS TO INFORM PATIENTS ON HOW THEIR PROTECTED HEALTH INFORMATION (PHI) WILL BE USED. HIPAA PROTECTS ALL PHI THAT IS DEFINED AS "INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION" HELD OR TRASMITTED BY A COVERED ENTITY OR ITS BUSINESS ASSOCIATES, IN ANY ORM OR MEDIA, WHETHER ELECTRONIC, PAPER OR ORAL.

AS A DENTAL OFFICE, WE USE AND DISCLOSE YOUR PHI TO EXECUTE TREATMENT, PAYMENT, AND HEALTHCARE OPTIONS ONLY. WE DO NOT SELL OR UTILIZE YOUR INFORMATION FOR MARKETING.

WAYS YOU PHI WILL BE USED:

TREATMENT: WE MAY USE OR DISCLOSE YOUR PHI TO A PHYSICIAN OR OTHER HEALTHCARE PROVIDER ESTABLISHING A TREATMENT PLAN FOR YOU.

PAYMENT: WE MAY USE OR DISCLOSE YOUR PHI TO OBTAIN PAYMENT FOR SERVICES PROVIDED TO YOU.

APPOINTMENT REMINDERS: WE MAY USE OR DISCLOSE YOUR PHI TO PROVIDE YOU WITH APPOINTMENT REMINDERS (PHONE CALLS, TEXT MESSAGES, EMAILS, OR MAIL)

ABUSE/NEGLECT: WE MAY USE OR DISCLOSE YOUR PHI TO AUTHORITIES IF WE REASONABLY BELIEVE YOU ARE A POSSIBLE VICTIM OF ABUSE, NEGLECT, DOMESTIC VIOLENCE, OR OTHER CRIMES.

NATIONAL SECURITY: WE MAY DISCLOSE TO AUTHORITIES THE PHI OF ARMED FORCES PERSONNEL UNDER CERTAIN CIRCUMSTANCES. WE MAY DISCLOSE TO AUTHORITIES FEDERAL OFFICIALS PHI REQUIRED FOR LAWFUL INTELLEGENCE, COUNTERINTELLEGENCE, AND OTHER NATION SECURITY ACTIVITIES. WE MAY DISCLOSE PHI TO LAW ENFORCEMENT AGENCIES OR CORRECTIONAL INSTITUTIONS.

RELEASE OF PHI TO AUTHORIZED PERSONNEL: WE WILL DISCLOSE YOUR PHI TO THE PERSON YOU HAVE AUTHORIZED BELOW. WE WILL RELEASE INFORMATION TO THE EXTENT NECESSARRY TO HELP WITH YOUR HEALTHCARE OR WITH PAYMENT FOR YOUR HEALTHCARE. ADD AUTHORIZED PERSON(S) BELOW.

NAME: _____ RELATIONSHIP: _____ PHONE: _____

SIGNATURE _____ DATE _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT DR. SHAIA MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE RELEASE OR DISTRIBUTE SUCH INFORMATION TO MY INSURANCE COMPANY AND AGENTS IN THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES RENDERRED.I RELEASE ALL INURANCE BENEFITS FOR MYSELF AND MY MINOR BE ASSIGNED TO DR. SHAIA, WITH ANY UNPAID BALANCES COVERED BY THE RESPONSIBLE PARTY.

SIGNATURE _____ DATE _____

EMERGENCY CONTACT

IN THE CASE OF A MEDICAL AND/OR WELLNESS EMERGENCY WHO MAY WE CONTACT?

NAME: _____ RELATIONSHIP: _____ PHONE: _____

BROKEN APPOINTMENT AUTHORIZATION

RESERVATIONS WITH OUR OFFICE REQUIRE A MINIMUM OF 24 HOUR NOTICE WHEN RESCHEDULING AND/OR CANCELLING. MISSED AND/OR BROKEN APPOINTMENTS WITHOUT 24 HOUR NOTICE WILL BE SUBJECT TO A CANCELLATION FEE THAT MUST BE PAID PRIOR TO THE NEXT RESERVATION. SATURDAY NO SHOWED VISITS WILL RESULT IN LOSS OF ACCESS TO WEEKEND VISITS. FREQUENT BROKEN VISITS MAY WARRANT DISMISSAL. IF YOU NEED TO ALTER A RESERVATION WE CAN BE REACHED BY PHONE AND/OR TEXT MESSAGE.

BROKEN RESERVATION WITH DR. SHAIA ***$50 +*** *BROKEN RESERVATION WITH HYGIENE* ***$25 +***

SIGNATURE _____ DATE _____

NAME: _____ **DATE:** _____

DENTAL HISTORY

REASON FOR TODAYS VISIT _____ DATE OF LAST CLEANING _____

FORMER DENTIST _____ DATE OF LAST XRAYS _____

HOW OFTEN DO YOU BRUSH? _____ HOW OFTEN DO YOU FLOSS? _____

CHECK BOX IF YOU HAVE HAD CONCERNS WITH ANY OF THE FOLLOWING:

☐ BAD BREATH	☐ GUM DISEASE	☐ LOOSE TEETH
☐ BLEEDNG GUMS	☐ BITING SENSITIVITY	☐ SORES/GROWTHS
☐ CLICKING/POPPING JAW	☐ TEMPERATURE SENSITIVITY	☐ BROKEN FILLINGS
☐ FOOD COLLECTION	☐ SWEETS SENSITIVITY	☐ GRINDING TEETH

MEDICAL HISTORY

PHYSICIANS NAME _____ DATE OF LAST VISIT _____

HAVE YOU EVER USED A BISPHOSPHONATE MEDICATION? (FOSAMAX, BONIVA, ACTONEL) ☐ YES ☐ NO

HAVE YOU EVER TAKEN ANY OF THE GROUP OF DRUGS COLLECTIVELY REFERRED TO AS "FEN-PHEN"? THESE INCLUDE IONIMIN, ADIPEX, FASTIN (BRAND NAMES OF PHENTERMINE), PONDIMIN (FENFLURAMINE) AND REDUX (DEXFENFLURAMINE). ☐ YES ☐ NO

SERIOUS ILLNESS OR OPERATIONS? ☐ YES ☐ NO IF YES, DESCRIBE _____

BLOOD TRANSFUSION? ☐ YES ☐ NO IF YES, APPROXIMATE DATE _____

(WOMEN) ARE YOU PREGNANT? ☐ YES ☐ NO NURSING: ☐ YES ☐ NO

PLEASE MARK YES OR NO FOR THE FOLLOWING:

YES	NO		YES	NO		YES	NO	
☐	☐	ANEMIA	☐	☐	DIABETES	☐	☐	HIV/AIDS
☐	☐	ARTHRITIS, RHEUMATISM	☐	☐	EPILEPSEY	☐	☐	LIVER DISEASE
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	FAINTING	☐	☐	RADIATION
☐	☐	ARTIFICIAL JOINTS/PINS	☐	☐	GLAUCOMA	☐	☐	HEADACHES
☐	☐	ASTHMA	☐	☐	RHEUMATIC FEVER	☐	☐	SCARLET FEVER
☐	☐	BACK PROBLEMS	☐	☐	HEART MURMUR	☐	☐	PACEMAKER
☐	☐	BLEEDING ABNORMALLY	☐	☐	HEART PROBLEMS	☐	☐	SKIN RASH
☐	☐	BLOOD DISEASE	☐	☐	HEMOPHILIA	☐	☐	STROKE
☐	☐	CANCER	☐	☐	THYROID PROBLEMS	☐	☐	FEET SWELLING
☐	☐	CHEMICAL DEPENDENCY	☐	☐	HERNIA REPAIR	☐	☐	HEPATITIS
☐	☐	CHEMOTHERAPY	☐	☐	HIGH BLOOD PRESSURE	☐	☐	TOBACCO HABIT
☐	☐	CIRCULATORY PROBLEMS	☐	☐	SHORTNESS OF BREATH	☐	☐	TONSILITIS
☐	☐	CONGENITAL HEART LESIONS	☐	☐	VENEREAL DISEASE	☐	☐	TUBERCULOSIS
☐	☐	CORTISONE TREATMENTS	☐	☐	KIDNEY DISEASE	☐	☐	ULCER
☐	☐	COUGH, PERSISTENT	☐	☐	RESPIRATORY DISEASE	☐	☐	JAW PAIN
☐	☐	COUGH UP BLOOD	☐	☐	MITRAL VALVE PROLAPSE			

CURRENT MEDICATIONS AND DIAGNOSIS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IN ACCURATE.

SIGNATURE _____ DATE _____

Shaia Dental Care

Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the the finest care available.

DATE: _____

PATIENT INFORMATION

NAME _____ BIRTHDATE _____ SSN _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____ EMAIL _____

SEX ☐ M ☐ F ☐ MARRIED ☐ WIDOWED ☐ PARTNERED

☐ SEPARATED ☐ DIVORCED ☐ SINGLE ☐ MINOR

EMPLOYER/SCHOOL _____ EMPLOYER/SCHOOL PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____ RELATIONSHIP _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP TO PATIENT ☐ SELF ☐ OTHER _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____	SECONDARY INSURANCE _____
SUBCRIBER ID _____	SUBCRIBER ID _____
☐ SELF ☐ SPOUSE ☐ DEPENDENT	☐ SELF ☐ SPOUSE ☐ DEPENDENT
HAVE YOU USED DENTAL BENEFITS AT ANOTHER OFFICE THIS YEAR? ☐ NO ☐ YES	HAVE YOU USED DENTAL BENEFITS AT ANOTHER OFFICE THIS YEAR? ☐ NO ☐ YES

FINANCIAL AGREEMENT

IN AN EFFORT TO REDUCE COSTS, INCREASE EFFICIENCY AND MAINTAIN A HIGHER LEVEL OF PATIENT AND PROFESSIONAL CARE, WE HAVE CREATED A FINACIAL POLICY THAT BOTH PATIENTS AND OFFICE PERSONNEL MUST ADHERE TO. OUR FINANCIAL POLIICY IS AS FOLLOWED:

1. OUR OFFICE WILL ASSIST YOU IN PROCESSING YOU INSURANCE CLAIMS, PLEASE UNDERSTAND IT IS YOUR RESPONSIBILITY TO SATISY ANY AND ALL ACCOUNT BALANCES FOR ALL SERVICES RENDERED; AN INSURANCE ESTIMATE WILL BE PROVIDED AS A COURTESY. EXTENSIVE PROCEDURES MAY REQUIRE PREDETERMINATION TO PERFORM SERVICES FROM YOUR INSURANCE. THIS PROCESS TAKES 30-45 DAYS.

2. DENTAL BENEFIT ESTIMATES ARE DUE AT THE TIME SERVICES ARE RENDERED. IF THERE ARE ANY BALANCES AFTER INSURANCE MAKES OR DENIES PAYMENT, A STATEMENT WILL BE SENT IN THE MAIL FOR PROMPT PAYMENT.

3. WE ACCEPT PAYMENT BY CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, HEALTH SAVINGS ACCOUNTS, AND CARE CREDIT. IN AN EFFORT TO MAKE DENTISTRY OBTAINABLE, WE DO OFFER LIMITED IN HOUSE PAYMENT ARRANGEMENTS.

☐ I UNDERSTAND AND COMPLY WITH THE FINANCIAL POLICY

SIGNATURE _____ DATE _____

ANTHONY A. SHAIA D.D.S