Twin Cities Periodontics

Registration

Exceptional periodontal and dental implant care

Patient name			Preferred name	Today's date	
Birthdate	Age	Sex	Social Security #		
Street address			City	State	Zip Code
Home Phone	Cell Phone		E-mail address		
Your employer name/address			Office phone		
Spouse's name			Spouse's employer name/address		
Who may we contact for appointment scheduling if unable to reach you?			Phone		
Who should we contact in case of emergency?			Phone		
Who may we thank for referring you to us?					
Who will be responsible for this account:?					
Do you have insurance coverage for dental treatment? ☐ YES ☐ NO **If YES, please complete insurance form below.**					

A Service to Our Insured Patients

Most of our insured patients ask that we process their insurance forms for them. We are able to do this, but only if provided with the necessary information. If you want us to process your insurance forms, please complete the section below. Thank you.

Policyholder name	ID or Social Security # of policyholder
Birth date of policyholder	Patient's relationship to policyholder
Insurance company name and address	
Group #	Is patient covered by another dental plan? ☐ YES ☐ NO

Signature on File Statement

I authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents.

I further authorize Twin Cities Periodontics to submit claims for benefits to my insurance carrier for services provided or to be provided without obtaining my signature on every claim submitted for myself and/or dependents. I will be bound by this signature as though I had personally signed the particular claim.

I also authorize assignment of benefits directly to the provider of services.

Signature of Covered Person/Policyholder _____ Date _____

Secondary Insurance

If you would like us to process your secondary insurance forms, please complete the section below. Thank you.

Policyholder name	ID or Social Security # of policyholder
Birth date of policyholder	Patient's relationship to policyholder
Insurance company name and address	
Group #	

Signature on File Statement

I authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents.

I further authorize Twin Cities Periodontics to submit claims for benefits to my insurance carrier for services provided or to be provided without obtaining my signature on every claim submitted for myself and/or dependents. I will be bound by this signature as though I had personally signed the particular claim.

I also authorize assignment of benefits directly to the provider of services.

Signature of Covered Person/Policyholder _____ Date _____

OVER

CANCELLATION POLICY

We appreciate the fact that your time is very important. If you need to cancel a cleaning appointment, we require **two** business days notice. For cancellation of surgical and gingival therapy appointments (root planing), our office requires **five** business days notice.

If we do not receive the required notice and if we are not able to fill the cancellation, we reserve the right to charge for these cancelled appointments. Thank you for your courtesy.

I have read and understand the above policy: _____ _____

Signed *Date*

Patient Name	Date

Dental & Health History

Dentist name	Phone		
Address	City	State	Zip

Do you have any current dental complaints? ☐ YES ☐ NO If yes, explain:

Do you currently have any unhealed injuries, inflamed areas, growths, lumps or sore spots in your mouth? ☐ YES ☐ NO If yes, explain:

Do you currently smoke? ☐ YES ☐ NO How much? For how long?

Medical History

Physician Name	Phone		
Address	City	State	Zip
Date of last physical exam	WOMEN ONLY:		
On a special diet? ☐ YES ☐ NO If yes, explain:	Pregnant? Due date: _____/_____/_____		
	Breast feeding? ☐ YES ☐ NO		

Are you currently under medical treatment? ☐ YES ☐ NO If yes, explain:

Are you currently taking prescription medication? ☐ YES ☐ NO If yes, list name & dosage:

Are you currently taking any over-the-counter medications (aspirin, multi-vitamins, herbal)? ☐ YES ☐ NO

If YES, do you regularly take any of the following:

☐ Diet or energy supplements ☐ Echinacea ☐ Garlic ☐ Ginger ☐ Ginkgo ☐ Ginseng ☐ Kava ☐ St. John's Wort

☐ Valerian ☐ Vitamin E.400I.U. ☐ Fish oil >3 grams/day

Do you regularly use natural or herbal oral health products? ☐ Yes ☐ No Have you recently stopped taking any herbs? ☐ Yes ☐ No

Have you substituted herbs for prescription or over-the-counter drugs? ☐ Yes ☐ No

Are you allergic to any medication? ☐ Yes ☐ No If yes, list:

Are you allergic to local anesthetic (Novocaine)? ☐ Yes ☐ No Are you allergic to latex? ☐ Yes ☐ No

Please check (✓) any of the following that apply to you now or in the past:

Heart ailments:

- ☐ Myocardial infarction
- ☐ Congestive heart failure
- ☐ Angina (take nitro)
- *☐ Heart murmur
- *☐ Congenital heart disorder
- *☐ Rheumatic fever
- *☐ Prosthetic implant
- ☐ Abnormal blood pressure
- ☐ Circulatory problems
- ☐ Any major operations
- ☐ Complications of healing
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Blood disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Respiratory disease
- ☐ Anemia
- ☐ Stomach or intestional disorder
- ☐ Thyroid problem
- ☐ Tumors or growths
- ☐ X-rays or radiation therapy
- ☐ Epilepsy, convulsions
- ☐ Fainting spells
- ☐ Stroke
- ☐ Abnormal bleeding
- ☐ Rheumatism or arthritis
- ☐ Glaucoma
- ☐ Sinus
- ☐ Asthma, hay fever, allergies
- ☐ Veneareal disease (syphillis, gonorrhea, herpes, or other)
- ☐ HIV
- ☐ Serious illness or accident
- ☐ Chemically dependent
- ☐ Treatment for osteoporosis or osteopenia
- ☐ History of prolonged bleeding
- ☐ Chemotherapy
- ☐ Other

* If you have checked any of these items, please call our office as the American Heart Association suggests that antibiotics may be needed prior to and after your examination.

For Office Use:

Date:_____ Patient's Signature:_____ Updated:_____

Date:_____ Patient's Signature:_____ Updated:_____

Date:_____ Patient's Signature:_____ Updated:_____

Date:_____ Patient's Signature:_____ Updated:_____

Date:_____ Patient's Signature:_____ Updated:_____

Date:_____ Patient's Signature:_____ Updated:_____

Date:_____ Patient's Signature:_____ Updated:_____

DENTAL INSURANCE AND YOU

THE PATIENT COMES FIRST

You deserve the right care and the right compensation. Dr. Skinner and Dr. Gaspard devise treatment plans tailored to provide you with the needed quality dental care. Dental insurance programs are designed to help, not cover completely, the cost of your dental treatment. Also, some periodontal procedures may not be covered at all.

YOUR PLAN'S COVERAGE

During the last decade, dental benefit plans became an integral part of health care planning. While these plans are made available to employees through companies, unions, and associations, each may vary considerably. Your employer, the purchaser of the insurance plan, selects the range of benefits. The insurance plans may provide only limited coverage or provide coverage of only specific services such as preventative dental care.

YOUR INSURANCE PLAN

Typical criteria and terms used by insurance carriers include:

Reasonable and customary fees
Yearly Maximums
Preauthorization

Each of these criteria and terms varies by plan and insurance carrier. To ensure you receive maximum benefits, we recommend that you read your insurance booklet and become familiar with your specific plan requirements. Low reimbursement may be the result of coverage purchased for the insurance plan. If you feel the dental benefits are inadequate, discuss this matter with your employer so that alternatives can be investigated.

INSURANCE CLAIMS

At Periodontal Associates we can help. We will process all of your insurance claims expeditiously. All you need to do is bring along your dental insurance card to your first appointment and complete the insurance section of the Registration and Health History Form in your packet. Along with helping you file and process your claims, we are happy to answer any of your insurance questions if you bring in your plan's benefit booklet.

DENTAL TREATMENT PAYMENT POLICY

We require payment at the time of treatment. Your insurance company will send payment directly to you. If your insurance company will only pay us directly, we will be happy to issue a credit check back to you.

We take pride in providing comfortable, quality dental care.

Please call 952-935-9009 *for care you can trust*.

DENTAL HISTORY FORM

1. How many times do you brush your teeth on a weekly basis? _____
2. What type of toothbrush do you use? Circle: Soft Medium Hard
3. Have you had previous periodontal treatment? Y N
4. Have you had orthodontic treatment? Y N
5. Have you had your bite adjusted? Y N
6. Have you worn a bite plane, nightguard, or other appliance? Y N
7. Do your gums bleed when you brush or floss? Y N
8. Have you noticed any loose or shifting teeth? Y N
9. Have you noticed any bad tastes or bad breath? Y N
10. Are any of your teeth sensitive to heat, cold, sweets, brushing, or flossing? Y N
11. Does food tend to become caught between your teeth? Y N
12. Have any of your family members had significant dental treatment or tooth loss? Y N
13. Would you be concerned if you lost your teeth and had to wear false teeth? Y N
14. What do you like most about your teeth? _____
15. What do you like least about your teeth? _____
16. Are you happy with the appearance of your teeth? Y N
17. Have you recently been under more nervous tension than average? Y N
18. Are you aware of grinding your teeth? Y N
19. Are you aware of clenching your teeth together? Y N
20. Have you noticed clicking, popping, or pain in your jaw joints? Y N
21. Have you had headaches on a regular basis in the morning, evening, or after eating? Y N

WE ARE CONCERNED ABOUT YOU

Please check off the statements that apply to you so we can provide you with the best possible care.

1.	I am nervous being in a dental chair.	Y	N
2.	I have had a bad experience in a dental office.	Y	N
3.	I am concerned about lying back in a dental chair.	Y	N
4.	I have had difficulty with gagging or suctioning.	Y	N
5.	I would like to take breaks during long appointments.	Y	N
6.	I do not like dental noises such as drilling or suctioning.	Y	N
7.	I have not been to a dentist in a long time, and I am afraid of what you might say about my teeth or dental hygiene.	Y	N
8.	I have concerns about my treatment being uncomfortable.	Y	N
9.	I am not comfortable having doctors lecture me.	Y	N
10.	I will need to relay what you tell me to my spouse or another.	Y	N
11.	I do not like dental shots (or have had a bad experience with them).	Y	N
12.	I have concerns about eating or chewing.	Y	N
13.	I have concerns about insurance or finances.	Y	N
14.	I have another question or concern. (Please write below.)		

_____

_____

_____

_____

Thank you for sharing your concerns!

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.

{Twin Cities Periodontics}

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 (MM/DD/YR), 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.___ for each page, $___ 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: Shirlee Sova

Telephone: (952)935-9009 Fax: (952)935-1006

E-mail: shirlee@twincitiesperiodontics

Address: 3555 Louisiana Ave. So. St. Louis Park, MN.55426

{Twin Cities Periodontics}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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: Shirlee Sova

Telephone: (952)935-9009 Fax: (952)935-1006

E-mail: shirlee@twincitiesperio.com

Address: 3555 Louisiana Ave. So. St. Louis Park, MN. 55426

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, _____, 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 this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

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.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____