## REGISTRATION

Date: _____

Patient's Name: _____ How do you prefer to be addressed? _____

Sex: Male Female Age: _____ Birth Date: _____ SSN: _____

Single Married Divorced Widowed E-mail Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Work Ph: : _____

Occupation: _____ Employer: _____

Responsible Party on Account (if different from above): _____

Relationship to Patient: _____ Phone: _____ Home Cell Work (circle one)

Responsible Party Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Ph: _____

Whom may we thank for referring you to our office? _____

Purpose of Today's Visit? _____

How would you like to receive correspondence from our office? (Circle all that apply)

**TEXT MESSAGE** **EMAIL** **PHONE CALL**

## DENTAL INSURANCE

**PRIMARY** – Policy Holder's Name: _____ Employer: _____

Birth Date: _____ Insurance Phone #: _____ Relationship to Patient: _____

Ins. Provider: _____ Member/Subscriber ID/SSN: _____ Group #: _____

**SECONDARY** – Policy Holder's Name: _____ Employer: _____

Birth Date: _____ SSN: _____ Relationship to Patient: _____

Ins. Provider: _____ Member/Subscriber ID: _____ Group #: _____

## Patient Consent

1. I authorize Avery, Meadows and Associates to take x-rays, photos, study models and other diagnostic aids as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payors and \or other health professionals.
2. I authorize the use of needed anesthetics, sedatives, and other medication. I am aware that this involves some risks, including but not limited to redness and swelling of tissues, pain , miscarriage, itching, vomiting, dizziness, cardiac arrest, drowsiness, and \ or lack of coordination.
3. I authorize the Practice to submit claims for services rendered to my insurance company on my behalf. I recognize that I am ultimately responsible for understanding my insurance benefits and **if, for any reason, my insurance company does not remit the estimated amount, I agree to pay the balance of my account.**
4. I authorize the Practice to release to staff, hospitals, other health care providers, and insurance companies, self - insurers or their representatives, any and all information, records, and other Diagnostic Material about my medical history, services rendered, or recommended treatment.
5. I am responsible for payment for all services rendered on my behalf. I recognize that I am responsible for all fees regardless of insurance coverage. I am responsible for understanding my insurance benefits and if my insurance company does not remit the estimated amount, I agree to pay the balance of my account.
6. I give my consent for the Practice to use before and after photographs of myself and my dental treatment for their business or promotional materials.

**Please read the following agreement carefully and agree to terms and conditions:**

X_____

Patient Signature (Parent/Guardian Signature if Patient is under 18)

Are you under a physician's care now? _____

Have you been hospitalized or had a major operation? _____

Have you ever had a serious head or neck injury? _____

Are you taking any pills, medications, or drugs? _____

Do you take or have you taken Phen-Fen or Redux? _____

Have you taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates? _____

Are you on a special diet? _____ Do you use Tobacco?_____Do you use controlled substances?_____

Women : Pregnant \Trying to get pregnant?_____ Nursing? _____ Taking Birth control? _____

Are you allergic to any of the following? Circle all that apply Other _____

Aspirin Penicillin Codiene Acrylic Metal Latex Sulfur Local Anesthetics

Do you have or have you had any of the following? Circle all that apply

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

Have you had any serious illness not listed above? _____

To the best of my knowledge, I have answered the questions above accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes to my health.

Signature of Patient\Parent Guardian _____Date _____

Effective date of notice: January 1, 2016

**NOTICE OF PRIVACY PRACTICES**

**Drs. Avery, Meadows and Associates**
***3491 Walnut Grove Rd***
***Memphis, Tn. 38111***
901-452-0040

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
uses or disclosures for health related research;
uses and disclosures to prevent a serious threat to health or safety;
uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
other uses and disclosures affected by state law.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

**APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

**OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:
ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day

extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

**OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

**COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

**FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

# Drs. Avery, Meadows and Associates

## Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy of Drs. Avery and Meadows. I hereby authorize, as indicated by my signature below, Drs. Avery and Meadows to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Phone Number

_____ _____

Signature Date

**Please check your preferred means of communication:**

__ You may contact me on my home telephone _____

__ You may contact me on my cell phone _____

__ You may contact me on my work telephone _____

__ You may send me an email _____

__ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from the list in the future.

1. _____ Relationship: _____ Date_____ added / removed
2. _____ Relationship: _____ Date_____ added / removed
3. _____ Relationship: _____ Date_____ added / removed

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining the acknowledgement

__ Other _____

Staff Person Initials ____