RINO
DENTAL

WHAT BRINGS YOU IN TODAY? ______________________

PATIENT INFORMATION

Full Name: ______________________
Last First M.I

Address: ______________________
Street Address Apt/Unit

____
City State ZIP

Phone: ( ) ( ) ( )
Home Cell Work

Email: ______________________

SSN or Gov't ID: ______________ Birth Date: ______________

INSURANCE INFORMATION

Carrier: ______________ Subscriber Name: ______________

Subscriber DOB: ______________ Employer: ______________

Member ID: ______________ Group #: ______________

Ins. Phone #: ______________ Ins. Address: ______________

EMERGENCY CONTACT INFORMATION

Full Name: ______________________
Last First M.I

Address: ______________________
Street Address Apt/Unit

____
City State ZIP

Phone #: ( ) ______________ Relationship: ______________

How did you hear about us? ______________________

MEDICAL HISTORY

Patient Name: ______________________ Age: ______

Name of Physician ______________________

Most recent physical exam: ______________________

	DO YOU HAVE OR HAD A HISTORY OF:	YES	NO
1	hospitalization for illness or injury	○	○
2	an allergic reaction to	○	○
	○ aspirin, ibuprofen, acetaminophen	○	○
	○ penicillin	○	○
	○ erythromycin	○	○
	○ tetracycline	○	○
	○ codeine	○	○
	○ local anesthetic	○	○
	○ fluoride	○	○
	○ metals (gold, stainless steel)	○	○
	○ latex	○	○
	○ any other medication	○	○
3	heart Problems	○	○
4	heart murmur	○	○
5	rheumatic fever	○	○
6	scarlet fever	○	○
7	high blood pressure	○	○
8	low blood pressure	○	○
9	a stroke	○	○
10	artificial prosthesis (i.e. heart valve or joints)	○	○
11	anemia or other blood disorder	○	○
12	prolonged bleeding due to a slight cut	○	○
13	emphysema	○	○
14	tuberculosis	○	○
15	asthma	○	○
16	breathing or sleep problems (i.e. snoring, sinus)	○	○
17	kidney disease	○	○
18	liver disease	○	○
19	jaundice	○	○
20	thyroid or parathyroid disease	○	○
21	hormone deficiency	○	○
22	high cholesterol	○	○
23	diabetes	○	○
24	stomach or duodenal ulcer	○	○
25	digestive disorders (i.e. gastric reflux)	○	○
26	osteoporosis/osteopenia (i.e. taking bisphosphonates)	○	○
27	arthritis	○	○
28	glaucoma	○	○
29	contact lenses	○	○
30	head or neck injuries	○	○
31	epilepsy, convulsions (seizures)	○	○
32	neurologic problems	○	○
33	any lumps or swelling in the mouth	○	○
34	viral infections and cold sores	○	○
35	hives, skin rash, hay fever	○	○
36	venereal disease	○	○
37	hepatitis (type _______)	○	○
38	HIV/ AIDS	○	○
39	tumor, abnormal growth	○	○
40	radiation therapy	○	○
41	chemotherapy	○	○
42	emotional problems	○	○
43	psychiatric treatment	○	○
44	antidepressant mediation	○	○
45	alcohol/drug dependency	○	○

	ARE YOU:	YES	NO
46	presently being treated for any other illness?	○	○
47	aware of a change in your general health?	○	○
48	taking medication for weight management?	○	○
49	taking dietary supplements?	○	○
50	often exhausted or fatigued?	○	○
51	subject to frequent headaches?	○	○
52	a smoker or smoked previously?	○	○
53	often unhappy or depressed?	○	○
54	FEMALE—taking birth control pills?	○	○
55	FEMALE— pregnant?	○	○
56	MALE— prostate disorders?	○	○

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment .

____

List all medications, supplements, and or vitamins taken within the last two years.

____

____

*please advise us in the future of any change in your medical history or any medications you may be taking

Patient's Signature ______________________ Date: ______

Doctor's Signature ______________________ Date: ______

DENTAL HISTORY

What is your immediate concern?

Referred by: ______ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist ______ How long have you been their patient? ______ Months/Years

Date of recent dental exam and/or treatment ______ X-rays? ______

I routinely see my dentist every: ☐ 3mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ not routinely

Please answer YES or NO to the following:

		YES	NO
PERSONAL HISTORY			
1	Are you fearful of dental treatment?	○	○
2	Have you had an unfavorable dental experience?	○	○
3	Have you ever had complications from past dental treatment?	○	○
4	Have you ever had trouble getting numb or reactions to local anesthetic?	○	○
5	Did you ever have braces, orthodontic treatment or had your bite adjusted?	○	○
SMILE CHARACTERISTICS			
7	Is there anything about the appearance of your teeth that you would like to change?	○	○
8	Have you ever whitened (bleached) your teeth?	○	○
9	Are you self-conscious about your teeth?	○	○
10	Have you had any teeth removed?	○	○
BITE & JAW JOINT			
11	Do you/would you have any problems chewing gum, bagels or other hard foods?	○	○
12	Have your teeth changed in the last 5 years, become shorter, thinner or worn?	○	○
13	Are your teeth crowding or developing spaces?	○	○
14	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	○	○
15	Do you have any problems with sleep or wake up with an awareness of your teeth?	○	○
16	Do you have any problems with your jaw joint?)pain, sounds, limited opening, locking, popping)	○	○
17	Do you have tension headaches or sore teeth?	○	○
18	Do you wear or have you ever worn a bite appliance?	○	○
TOOTH STRUCTURE			
19	Have you had any cavities within the past 3 years?	○	○
20	Do you have a dry mouth?	○	○
21	Are any teeth sensitive to hot, cold biting or sweets?	○	○
22	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	○	○
23	Do you avoid brushing any part of your mouth?	○	○
24	Do you feel or notice any holes (i.e. pitting) in your teeth?	○	○
GUM & BONE			
25	Have you ever been diagnosed or treated for periodontal (gum) disease?	○	○
26	Have you ever experience gum recession?	○	○
27	Is there anyone with a history of periodontal disease in your family?	○	○
28	Do you gums bleed when brushing, flossing or eating?	○	○
29	Are you teeth becoming loose?	○	○
30	Have you ever noticed an unpleasant taste or odor in your mouth?	○	○
31	Have you experienced a burning sensation in your mouth?	○	○

Patient's Signature ______ Date: ______

Doctor's Signature ______ Date: ______

HIPAA Notice of Privacy Practices

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

RiNo Dental, hereafter referred to as "Practice", is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI", to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 03/25/2015. You may Access or obtain a copy according to the following options: 1) our website at http://www.rinodental.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time or your next appointment.

1. USES & DISCLOSURES OF PHI. Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you. A) Treatment B) Payment C) Healthcare Operations i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows: D) Required or Permitted by Law: This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies , reports of child abuse or neglect, if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law, Food and Drug Administration for the quality, safety, or effectiveness or FDA-regulated products or activities, in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process, to law enforcement, coroner or medical examiner for identification purposes, researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI, as authorized to comply with workers' compensation laws, if you are an inmate of a correctional facility and this information is necessary for your care. Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosers that Require Your Permission or Objection: *E) Students*: We may share PHI with students working in our Practice to fulfill their educational requirements. F) *Appointment reminders*: We may contact you via voicemail, postcard, email as a reminder of your appointment with a provided preferred means of contact. G) *Family, Close Friends, Personal Representatives & Care Givers:* Our staff may disclose relevant PHI to personal involved in your care or payment with provided information. If you are unable to agree or object to such disclosure, we may disclose information as necessary if we determine that it is in your best interest based on our professional judgement. If a young adult age eighteen (18) requests that his/her information not be released to a parent/guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents have access to PHI with legal parental rights. Payment of services in addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. A) Copy of this Notice. B) Inspect and Copy PHI: You must submit a written request with preferred copy method (electronic or paper). According to state and federal law, we may charge you a reasonable tee to copy your records. Our Practice does not transmit unsecure PHI via email. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the privacy officer for more details). C) Amendment: Please consult with privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record is if we did not create the information or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our practice. D) Restrictions. You have the right to request a restriction of your PHI through writing to our Privacy Officer. However, your provider is not required to agree to this restrictions and is open for discussion. E) Confidential Communications: You have the right to request to receive confidential communications form our Practice by alternative means or at an alternative location. F) Disclosures: You have the right to request an accounting of disclosures including those made through Business Associate as west forth in CFR 45 CFR§ 164.520. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through HER. G) Breach Notification: You have the right to be notified following a breach of unsecured PHI that affects you. H) Fundraising: PHI for fundraising , basic requirements must be satisfied to include notice to you and to opt out. Note: Your PHI is not used in this manner.

3. COMPLAINTS. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S Department of Health & Human Services, Office of Civil Rights, 200 Independence Ave SW, Washington, DC 20201. Your complaint must be filed in writing by mail, fax or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit www.hhs.gov.ocr/hipaa/for more information. If you have questions, would like additional information or want to report a problem regarding the handling of you PHI, you may contact the Privacy Officer at:

RINO DENTAL

3258 LARIMER ST STE 300

TEL: 303. 292-3120

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

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

____

Print Name Address

____

Signature Date

PLEASE CHECK YOUR PREFERRED MEANS OF COMMUNICATION

☐ Home # ____________________

☐ Mobile # ____________________

☐ Work # ____________________

☐ Unencrypted email/text ____________________

☐ Other ____________________

PLEASE LIST AUTHORIZED PERSONAS WITH WHOM WE MAY DISCUSS YOUR PROTECTED HEALTH INFORMATION (PHI) IN ADDITION TO CUSTODIAL PARENTS AND LEGAL GUARDIANS

1. ______________________________ Date Added/ Removed: ____________
2. ______________________________ Date Added/ Removed: ____________
3. ______________________________ Date Added/ Removed: ____________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice or 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 (Specify)____

Staff Personal Initials __________

FINANCIAL POLICY

We thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding these matters.

If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

For your convenience we accept Visa, MasterCard and Discover. We deliver the finest care at the most reasonable cost to our patients, therefore payment is due at the time service is rendered unless other arrangements have been made in advance. A $35.00 service fee will be charged for all returned checks. Additionally you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Initials

_______ Interest may incur if a balance remains unpaid after 60 days

_______ It is your responsibility to provide all insurance eligibility, identification, authorization and referral information with changes as they occur. A preauthorization of services does not always guarantee payment from insurance. Photo ID is required for insurance information. Failure to do so necessitate patient payment for all charges. We are contractually obligated to collect copayments, co-insurance and deductibles as outlined by your insurance carrier.

_______ Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. You as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees.

_______ We require notice of cancellations 24 hours in advance. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are $50.00/hr but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may result in your dismissal from the practice

- **We strive to see our patients within the allotted time. If we are running 15-20 minutes behind schedule, we will try our best to accommodate the new appointment according to your convenience.**
- **For late appointments we ask you to call the office as soon as possible. As courtesy we may be able to accommodate you; however, we may have to reschedule your appointment to fulfill scheduled patient appointments.**
- **Please note that you will be re-scheduled if you are 15 minutes late for an appointment.**

____

Print Name

____

Signature **Date**