AIRPARK
FAMILY DENTISTRY

1060 Holland Ave – Philadelphia, MS 39350
Ph: (601)656-3275 Email: airparkfamilydentistry@yahoo.com

Patient Legal Name: _____ Goes By: _____
First: Middle: Last:

Address: _____ City: _____

State: _____ Zip:_____ Email Address: _____

Phone (H): _____ Cell: _____ Work: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Sex: M/F Marital: S/M/D/W

For Insured Patients

Policy Holder Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____ Relation to patient: _____

Phone: _____ Address(if different than patients'): _____

Employer: _____ INS Company: _____

ID#: _____ Group #: _____

INS Address: _____ INS Phone #: _____

Responsible Party (this would be the person responsible for any balance after Insurance payment)

Name: _____ Relations to Patient: _____

Mailing Address: _____ Phone: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

PLEASE READ THE FOLLOWING CAREFULLY THEN SIGN AND DATE

*****I understand I am responsible for the cost of my dental treatment**

*****I authorize and consent to the release of necessary information to my dental insurance company**

*****I authorize payment of group benefits to Airpark Family Dentistry**

Signed: _____ Date: _____

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Patient Name: _____

Who referred you to our office? _____

Do you have a preference in which doctor you see? Circle one: Dr. Steele/Dr. Saxon/I have no preference

Have you been hospitalized in the last 2 years? Y/N Are you currently under the care of a physician? Y/N

Physicians Name: _____

Please mark "x" to indicate you currently or have ever had any of the following conditions:

Abnormal Bleeding	_____	HPV	_____
Adrenal Disorder	_____	Kidney Disease	_____
AIDS	_____	Liver Disease	_____
Anemia	_____	Low Blood Pressure	_____
Arthritis	_____	Lung Disease/COPD/Emphysema	_____
Artificial Joints	_____	Lupus	_____
Artificial Valves	_____	Migraines	_____
Asthma	_____	Mitral Valve Prolapse	_____
Cancer/Chemotherapy	_____	Multiple Sclerosis	_____
Chronic Pain	_____	Osteoporosis	_____
Congestive Heart Failure	_____	Pacemaker	_____
Convulsions/Seizures	_____	Reflux	_____
Dementia	_____	Respiratory Problems	_____
Diabetes	_____	Rocky Mtn. Spotted Fever	_____
Epilepsy	_____	Sinus Problems	_____
Grinding or Clenching teeth	_____	Stroke	_____
Heart Attack/Disease/Murmur	_____	Thumb Sucking Habit	_____
Hepatitis	_____	Thyroid Disorder	_____
High Blood Pressure	_____	Ulcers	_____

***In case of emergency we may contact: _____ **Relation:** _____ **Phone:** _____

_____

Are you taking any medications currently? If yes, please list them: _____

_____

Do you have any allergies/Are you allergic to any medications? Please list them here: _____

_____

_____

Preferred Pharmacy: _____

Are you pregnant? Y/N If yes, how many weeks?_____

***The medical information I have provided is true and accurate to best of my knowledge.**

Signed _____ Date_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent, I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

Airpark Family Dentistry
1060 Holland Avenue
Philadelphia, MS 39350
Phone: 601-656-3275

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

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.

Signed _____ Date _____

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FAMILY DENTISTRY

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.
As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your dental records only for each of the following purposes: treatment, payment, and health care operations.
Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to receive an accounting of disclosures of protected health information.
The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of April 12, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.