WELCOME TO STEINBICKER DENTISTRY!

We are delighted that you have chosen us to meet your dental care needs! Attached please find our new patient document package. Filling these documents out and returning them prior to your appointment will assure a timely check-in process. Please attach insurance cards as well. Please fill one form for each person that will be attending our office. The documents enclosed include: patient information questionnaire, medical history questionnaire, our office's notice of privacy practices (you may keep this form for your records), and a record request form (if you would like any records from a previous dentist transferred to our office).

We look forward to meeting you soon!

206 Fieldale Road
Mebane, NC 27302
info@mebanedentistry.com
phone: (919) 563-4600
fax: (919) 563-4602

STEINBICKER DENTISTRY

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI:_____

If dependent, Guardian's Name:_____ Patient Preferred Name: _____

Date of Birth: _____ Marital Status: Single ☐ Married ☐ Child ☐ Other ☐ ☐ Male ☐ Female

Social Security #: _____ Driver's License #: _____

Street Address: _____ City: _____ Zip: _____

Telephone: Home:_____ Work: _____ Cell: _____

E-mail: _____Referred by?_____

May we contact you via unsecured email, text messaging and phone numbers provided? ☐ Yes ☐ No
** For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately or by a third party. I still elect to move forward to allow email communications to occur. Text message appointment reminders will be sent to you. Future appointments can be confirmed using this text messaging service.*

Employer: _____ Address: _____ Zip: _____

Emergency Contact: _____ Phone number:_____ Relation:_____

DENTAL INSURANCE *(insurance subscriber)*

Subscriber Name: _____ Social Security Number _____ DOB: _____

Insurance Company: _____ Phone #:_____Group #: _____

Subscriber ID *(may be ss# of subscriber*): _____Do you have secondary insurance coverage? ☐ **Yes** ☐ **No**

NOTICE OF PRIVACY PRACTICES

I have reviewed Steinbicker Family Dentistry's *Notice of Privacy Practices*. I consent to the use or disclosure of my (or my child's) protected health information by this office for the purposes outlined in their *Notice of Privacy Practices*. I understand that at any time I may receive a copy of this notice in person.

May we release information to anyone? ☐ **Yes** ☐ **No**
If yes, to whom? Please list name, phone number, and relation (include caregivers, nannies, grandparents, etc. if necessary.

OFFICE POLICIES *(please read carefully)*

- We file and accept most insurance benefits, however we are <u>not</u> affiliated (in-network) with all insurances. We are currently in-network with Ameritas, BCBS, Cigna, Delta, Principle Life and United Healthcare.
- Knowing your insurance benefits is your responsibility. <u>You are responsible for fees not covered by insurance</u>.
- Financial responsibility on the part of each patient must be determined by the patient prior to dental treatment. <u>Payment in FULL is expected at time of service</u>.
- Balances over 30 days past due will be sent to collections or small claims court.
- Broken appointments with less than 24 hours notice will be charged a $25.00 broken appointment fee.
- Broken appointments, misconduct or failure to pay account balance in a timely manner may lead to dismissal as a patient.

BY SIGNING BELOW I ACKNOWLEDGE RECEIVING AND REVIEWING A COPY OF STEINBICKER DENTISTRY'S NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES. I CONSENT TO THE DIAGNOSTIC PROCEDURES AND TREATMENT BY DR. STEINBICKER AND TEAM NECESSARY FOR PROPER DENTAL CARE. ALL THE INFORMATION PROVIDED IS ACCURATE.

Patient/Guardian Signature: _____ Date:_____

STEINBICKER DENTISTRY

Last Name _____ First Name: _____ DOB: _____-_____-_____

MEDICAL HISTORY

Are you under the care of a physician? **Yes ☐ No ☐**

If yes, name of physician/facility? _____Phone #: _____

Last dental visit and location:_____ Date of last x-rays:_____

List ALL medications/supplements you are taking:

List ANY medicines/materials you are allergic to:

Are you allergic to latex? **Yes ☐ No ☐** Pregnant or think you might be? **Yes ☐ No ☐**

Do you require pre-medication with antibiotic before dental treatment? **Yes ☐ No ☐**

Circle ALL of the following you may have or have had in the past:

Hepatitis A/B/C	MAOI(s)	Diabetes	HIV/AIDS
Congestive Heart Failure	Psychiatric Disorder(s)	Asthma	Tuberculosis
Heart Disease	Blood Disorder(s)	Sulfa Allergy	Persistent Cough
High/Low Blood Pressure	Thyroid Disease	Seizures	Bloody Sputum
Infective Endocarditis	Kidney Disease	Stomach Problems	Night Sweats
Congenital Heart Defect	Liver Disease	Tobacco User	Weight Loss/Anorexia
Pacemaker/Artificial Heart Valves	Radiation/Chemo Therapy	Osteoporosis	Fever
Venereal Disease(s)	Cancer	Jaundice	Glaucoma
Inflammatory Diseases	Artificial joints/prosthesis	Rheumatic Fever	Cocaine

Other conditions/problems not listed, or comments:

Major Surgeries or serious illnesses *(include dates):* _____

Any other medical information we should know about you? _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE. I AM RESPONSIBLE FOR NOTIFYING STEINBICKER DENTISTRY OF ANY CHANGES IN MY MEDICAL HISTORY.

Patient/Guardian Signature: _____ Date:_____

STEINBICKER DENTISTRY

Notice of Privacy Practices

This notice describes how your personal health information (PHI) may be used and disclosed and how you can get access to this information.

Please review it carefully.

If you have any questions about this notice please contact Julie Burns, our Privacy Officer at (919) 563-4600 or info@mebanedentistry.com

Effective Date: August 1, 2007 Revised: October 27, 2015

Steinbicker Family Dentistry is committed to protecting your personal health information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This notice also describes your rights to access and control your PHI.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at (919) 563-4600.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

Health information exchange means that we can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for a root canal asks another doctor about your tooth history.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Examples: We use health information about you to manage your treatment and services.

Training students, other health care providers, or ancillary staff such as billing personnel to help them learn to improve their skills.

Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.

Use of information to assist in resolving problems or complaints within the practice.

Use of temporary employees when an employee is sick or unable to work.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. This may include but are not limited to billing companies, insurance companies, government agencies, collection agencies.

Example: We give information about you to your health insurance plan so it will pay for your services.

Appointment reminders

We may contact you as a reminder about upcoming appointments or treatment.

Business Associates

Some services are provided through the use of contracted entities called business associates (BA). We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the BA to appropriately safeguard your information.

Examples: insurance claim submission companies, appointment reminder companies, office operations repair companies.

Treatment alternative

We may provide you notice of treatment options or other health related services that may improve your overall health.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

STEINBICKER DENTISTRY

206 Fieldale Road ■ Mebane, NC 27302 ■ Telephone 919.563.4600 ■ Fax 919.563.4602 ■ mebanedentistry.com ■ info@mebanedentistry.com

Authorization to Release Personal Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____Phone _____

At my request, _____ may release the following information:

(Name of dental office releasing records)

- ☐ Entire record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Radiographs
- ☐ Other:

Entity or dental office that will be sending the information:

Name _____

Address_____

City, State, Zip _____Phone _____

☐ Send the information electronically. Email address: info@mebanedentistry.com

For **email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately or by a third party. I still elect to move forward to allow email communications to occur.*

☐ Send the information by mail to Steinbicker Dentistry, 206 Fieldale Road, Mebane, NC 27302

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)