PATIENT INFORMATION PAGE 1

PATIENT

PATIENT LAST NAME FIRST MIDDLE			PREFERRED NAME TO BE CALLED	☐ MALE ☐ FEMALE	TODAY'SDATE	
BIRTH DATE	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE		MARITAL STATUS ☐S ☐M ☐W ☐D	
MAILING ADDRESS			CITY		STATE	ZIP CODE
HOME ADDRESS			CITY		STATE	ZIP CODE
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?					RELATIONSHIP	

IF PATIENT IS UNDER AGE 21

MOTHER'S NAME	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER FINANCIAL CUSTODY? ☐MOTHER ☐FATHER ☐GUARDIAN ☐OTHER
FATHER'S NAME	

PATIENT / PERSON ACCOMPANYING PATIENT TODAY WHO IS RESPONSIBLE FOR PAYMENT

LAST NAME FIRST MIDDLE				RELATIONSHIP TO PATIENT ☐PARENT ☐SPOUSE ☐LEGAL GUARDIAN ☐OTHER
SOCIAL SECURITY NUMBER	PRIMARY PHONE #	SECONDARY PHONE #		
HOME ADDRESS ☐SAME AS ABOVE		CITY	STATE	ZIP CODE

PRIMARY DENTAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE			SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #		

PRIMARY MEDICAL INSURANCE ☐ NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE			SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #		

PLEASE CONTINUE TO PAGE 2

PATIENT INFORMATION PAGE 2

PATIENT'S NAME____

SECONDARY DENTAL INSURANCE ☐ **NONE**

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #		

SECONDARY MEDICAL INSURANCE ☐ **NONE**

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST	MIDDLE	SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		
EMPLOYER	BUSINESS ADDRESS		BUS. PHONE #		

________I understand that all payments for services are due on the date they are provided. After the receipt of insurance payment(s), my account balance is due within 14 days. Amounts received in excess of my account balance will be refunded to me.

________I understand that if I do not wish to provide my social security number I will be responsible to pay in full Dr. Banks' usual and customary fees for any services provided at the time the services are provided. I understand that I will be relinquishing my right to apply any negotiated insurance contract fees to my account balance, as well as the ability of Dr. Banks to submit insurance claims on my behalf.

____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

____

PRINTED NAME OF PATIENT PARENT OR GUARDIAN

____

TODAY'S DATE

____

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF DR. KATHY A. BANKS

HEALTH HISTORY

Patient's Name Date of Birth Height Weight Date

Physician's Name Physician phone #

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health?..Y N
2. Has there been any change in your general health in the past year? ....Y N
3. Date of last physical exam ____________________
4. Are you now under a physician's care for a particular problem?..Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.............Y N

____

____

6. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? ....Y N
   - B. Congenital Heart Disease? ....Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)?...............................Y N
   - D. Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ....Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?..Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ....Y N
   - G. Liver Disease (Jaundice, Hepatitis)?.....................Y N
   - H. Kidney Disease?..Y N
   - I. Diabetes?..Y N
   - J. Thyroid Disease (Goiter)? ....Y N
   - K. Arthritis?..Y N
   - L. Stomach Ulcers or Colitis? ....Y N
   - M. Glaucoma?...Y N
   - N. Osteoporosis? ....Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ....Y N
   - P. Radiation (X-ray) treatment for Cancer? ....Y N
   - Q. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?......Y N
   - R. Sinus or Nasal problems? ....Y N
   - S. Any disease, drug or transplant operation that has depressed your immune system?.............Y N
7. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?...Y N
   - B. Anticoagulants (Blood Thinners)?.........................Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications?........................Y N
   - E. Steroids (Cortisone, Prednisone, etc.)? ....Y N
   - F. Tranquilizers?...Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ....Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia) ? ....Y N
   - J. Have you ever been advised <u>not</u> to take a medication? ....Y N
   - K. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:______________________________________

   ____
8. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novacain, etc.)?........................Y N
   - B. Penicillin or other antibiotics? ....Y N
   - C. Sedatives, Barbiturates? ....Y N
   - D. Aspirin or Ibuprofen?..Y N
   - E. Codeine or other pain killers?...............................Y N
   - F. Latex or Rubber products?...................................Y N
   - G. Metal of any kind?..Y N
   - H. Chemicals or jewelry (rash or sensitivity)? ....Y N
   - I. Food products?..Y N
   - J. Other allergies or reactions? Please list ....Y N

   ____

   ____
9. Do you smoke or chew Tobacco?...............................Y N
   How much per day? _________
10. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?..Y N
11. Have you had any serious problems associated with any previous dental treatment? ....Y N
12. Have you or an immediate family member had any problem associated with intravenous anesthesia?.........Y N
13. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?..Y N
14. Do you wish to talk to the doctor privately about anything?..Y N
15. Have you ever had a bone density scan? ....Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? ....Y N
    - B. Are you nursing?...Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful and complete Health History to assist my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist.

Date Signature of Person Completing Health History Relationship

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

_________________________Patient giving consent_________________________________

Patient Name: ____

Address:____

Telephone #:___________________________E-Mail__________________________________

Patient's SSN#:________________________ Patient's Chart #__:______________________

________________________To the patient-please read 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 Privac 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 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 new 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, at any time by contacting:

Office Manager
Telephone (609) 488-2325
Fax (609) 488-2342
Address: 249 S. Main St. #4, Barnegat, NJ 08005

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice submitted to the contact person 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.

hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

______________Signature of Patient or Patient's Personal Representative________________

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

Signature:____ Date:_________________

If Personal Representative: ____________________________ Date:_________________

Print ____

Relationship to Patient:_______________________________

You are entitled to a signed copy of this Consent

Kathy A. Banks, DMD
249 South Main Street # 4
Barnegat New Jersey 08005

Cell Phone Use Policy:

Due to federal and state HIPAA Privacy and Confidentiality Regulations, NO cell phone use is permitted in patient care areas. This includes using your device for phone calls, photos, videotaping and recording.

Recording Policy:

We understand that in today's age, sharing of special moments and recording of life's events is easier than ever. While some venues are appropriate for documenting our experiences and even sharing through social media, we feel strongly that our facility is not one of those venues.
Unfortunately, recording of any type in our facility can often lead to unintended consequences. Often, patients may text or record (or have recorded) words or actions that they later regret, particularly if shared on social media. Their companions may inadvertently record images or voices of other patients violating *their* right to privacy, particularly given the setting.
For these reasons, as well as federal right to privacy regulations, ***our practice strictly forbids recording of any type while either in the facility or on our property without our prior written authorization.*** We respectfully ask that you or anyone who accompanies you to abide by this policy. Failure to sign this document or comply with this policy may lead to our refusal to treat you, dismissal from our practice and/or being asked to leave the facility and property.

By signing this document I am agreeing to abide by Dr. Banks' Cell Phone Use Policy and Recording Policy:

Signed:____ Date:______________________

Printed name:____

UNDERSTANDING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY.

You are responsible to contact your insurance company to obtain an ***estimate*** of ***potential reimbursement*** from your insurance companies for your/your child's planned procedures.

Your insurance company may determine that some, but not all, of the procedures are covered services, and your insurance companies may not pay in full for covered services.

Even if your insurance company informs you that a particular service is ”covered at 100% ” this does NOT necessarily mean that you will have no out of pocket expenses. You may have additional insurance plan circumstances that affect your actual out of pocket costs, such as:

> ***Deductibles****:* In an insurance policy, the deductible is the amount of expenses that must be paid out of pocket *by you* for medical or dental services *before* your insurer will pay any expenses. If you have not reached your deductible already, then you will have out of pocket expenses. *We have no means of obtaining your personal information regarding how much deductible you have paid. You should check this before treatment is rendered.*
>
> ***Co-pays:*** A Copayment or copay is a fixed payment for a covered service. The amount of your copay is defined by your insurance company, and must be paid by you each time you receive a medical or dental service. *Dr. Banks does not waive copays.*
>
> ***Denial after the fact:*** In rare cases, even after we have obtained an estimate of potential reimbursement from your insurance company, your insurance company can deny payment for services after the treatment occurs and when the claim is submitted. *Every effort will be made to assist you in appealing this unfortunate insurance decision and to obtain reimbursement for any covered services.*

As a courtesy to you, we will submit your insurance claims for you, and we will accept payment directly from the insurance company for any covered services, and outstanding balances will be billed to you and overpayments will be reimbursed. *Your other option is to pay in full for Dr. Banks' services and submit an insurance claim for reimbursement yourself. If you would like to submit claims yourself, please let us know.*

Remember, your insurance company exists to help *reimburse* for your medical and dental expenses. Your insurance company is not responsible to pay your bills. YOU are ultimately responsible to pay for services rendered to you or your dependent(s) in this office.

I have read and understand this statement:

Name (print)____

Signature____

Date____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DESCLOSED 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 11/1/2013, 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 the 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 official 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 that 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 the 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 $1.00 for each page, $25 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 the 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 Nov 1, 2013. 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 request.
Restriction: You have the right to request that we place additional restrictions or 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 handles 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.

QUESTION 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 tor 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 the 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 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: Office Manager C/O Dr. Kathy A Banks
Telephone: (609) 488-2325 FAX: (609) 488-2342
Address: 249S Main Street, Barnegat, NJ 08005