Merritt Family Dentistry

Patient Information

Today's date_____

Patient name_____ Preferred name _____

Date of birth_____ Status_____

Social Security#____-___-_____ Gender_____

Address_____City_____State____Zip Code_____

Email address_____

Home Phone _____Cell Phone _____Work Phone _____

Occupation_____ Employer_____

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

Person ultimately responsible for the account:

Name_____ Relationship_____

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

Dental Insurance company _____

Subscriber name _____ Date of Birth _____

Insurance #ID _____ Insurance Phone#_____

Group#_____ Employer_____

Do you have or ever had any of the following conditions?

☐ Allergy to any medications	☐ Artificial Joints	☐ Cancer
☐ Allergy to Latex	☐ Dementia	☐ Heart Murmur
☐ Anemia	☐ Heart Disease	☐ High Blood Pressure
☐ Blood disorder	☐ HIV	☐ Radiation Treatment
☐ Dizziness	☐ Mental Disorders	☐ Liver Disease
☐ Hepatitis	☐ Stroke	☐ Tuberculosis
☐ Kidney Disease	☐ Asthma	☐ Pacemaker
☐ Tumors	☐ Diabetes	☐ Rheumatic fever
☐ Epilepsy	☐ Fainting	☐ High Cholesterol

Are you currently pregnant or nursing?_____

List all medications, supplements, and/or vitamins taken:

_____

_____

_____

Please list any medications you are allergic to_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____

_____

Please list any recent surgeries or hospitalizations _____

_____

Do you use Tobacco?_____ Do you use controlled substances?_____

How would you rate your smile?

☐ excellent ☐ good ☐ fair ☐ poor

How many times do you floss?

☐ daily ☐ once per week ☐ 3-4 times per week ☐ never

How many times daily do you brush?

☐ once ☐ twice ☐ 3 times a day ☐ never

What type of toothbrush do you use?

☐ manual ☐ electric

Previous Dentist and phone number _____

Date of most recent dental exam/x-rays_____

How often do you have your teeth cleaned?

☐ 3months ☐ 4 months ☐ 6 months

Are you currently in pain or having in problems with your teeth? If so, please explain

_____

_____

List any dental problems you may be having:

☐ discomfort: popping or clicking of jaw

☐ lost or broken filling

☐ locking jaw

☐ blisters or sores in or gums

☐ ringing in ears

☐ teeth grinding

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Merritt Family Dentistry to release my records and any information requested to the following individuals.

1. **_____ Relation to Patient:_____**
2. **_____ Relation to Patient:_____**
3. **_____ Relation to Patient:_____**
4. **_____ Relation to Patient:_____**

Authorization Regarding Messages
(please check all that apply)

☐ **I authorize you to leave a detailed message on my home or cell number regarding appointments**

☐ **I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care or test results**

☐ **I authorize you to leave a message with anyone who answers the phone**

☐ **Messages may only be left with _____**

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

Effective date of notice: August 10, 2015

NOTICE OF PRIVACY PRACTICES

Merritt Family Dentistry, LLC
1441 North Point Lane
Mount Pleasant, SC 29464
843-352-9916 / fax 843-388-7649

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 any other reasons, we will request your 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 arise 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;

Unless you object, we will also share relevant information about your care with your family or friends who may be 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 be beneficial to you. Unless you inform us otherwise, we will mail you an appointment reminder on a post card and/or leave a reminder message on your home answering machine or with someone who answers your phone when 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 in our direct interest. Sometimes, you may initiate the process if you request 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 elect to sign, you may revoke the authorization 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 desire. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail address 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 compensate us for any extra costs incurred. 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; however, you will typically be able to review or receive a copy of your health information within 30 days of a request (or sixty days if the information is stored off-site). You may be asked 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 are allowed one 30 day extension on the time normally allotted for us to allow you access or photocopies. In such a case, we will send you a written notice of the extension. If you want to review or acquire 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 of your request. We will send the corrected information to persons who received incorrect information, and any other persons that you specify. If we do not agree, you can write a statement of your position, and we will include it and your health information along with any rebuttal statement that we may elect to write. Once your statement of position and/or our rebuttal is included in your health information, we will send them together 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 desire). 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, whether you received 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, if applicable.

COMPLAINTS

If you feel 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 address complaints directly 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 via phone.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

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Patient Name (Please Print) Patient Signature Date

Financial Policy Letter

We at Merritt Family Dentistry are proud to be a part of a team whose primary mission Is to deliver the finest and most comprehensive dental care services today. To assist you with your health care Investment, we are providing the following payment option.

***Please initial beside each section

PAYMENT:_____ Payment is due at the time of service. We do accept cash, personal checks with current date, major credit cards, debit cards and third-party financing through Care Credit.

INSURANCE:_____ As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, copayments, and non-covered amounts are due at the time services are rendered. ***All estimates quoted are based upon information provided to us by your insurance company and are estimates only they are not a guarantee of payment. The patient is ultimately responsible for all charges incurred.*** Insurance companies are required by law to pay claims within 30 days, After 60 days, any unpaid claims will be resubmitted by our office and we ask that you follow-up as well. After 90 days, we ask that you pay In full and have your insurance company reimburse you. We will be happy to provide any information or documentation you may require. Our first and only priority is our patients and the quality of care. The negotiation of benefits Is between you, your employer and Insurance company.

Some Insurance policies do not cover tooth-colored (composite) fillings. if your Insurance company adjusts the fee down to an alternate code for silver (amalgam) fillings you will be responsible for the difference.

RETURNED CHECKS:_____ All returned checks are subject to a $30.00 fee.

DELINQUENT ACCOUNTS:_____ Any past due account will be assessed a $10.00 fee per month. Accounts over 90 days past due will be referred out for collection and the patient Is responsible for any fees associated with that.

CANCELLATION POLICY:_____

It Is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities. ***We do require 24 hours' notice for cancellations and reschedules.*** This Is necessary to allow us adequate time to notify patients who are on a waiting 11st for the first available appointment. We are also then able to offer all our patients the same exceptional standard of care. ***A fee of $75,00 will be charged for fa lied or cancelled appointments with less than 24 hours' notice, regardless of reason. If you are more than 15 minutes late for your appointment we may have to cancel and apply a missed appointment fee to your account.***

I have read the above and understand and agree to these terms. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of benefits to be directly to Merritt Family Dentistry.

_____

Patient/Responsible Party Date