HAZEL GREEN DENTAL
Innovative technique. Traditional care.

14244 Highway 231/431 N
Hazel Green, AL 35750
P. 256.829.8878
E. info@HazelGreenDental.com
HazelGreenDental.com

New Patient Form

Welcome to our office. Thank you for the confidence you place with us to provide your dental care. In order for us to best serve you, please complete the following form. This information will aid us in providing the best services to meet your dental needs. If any of this information changes at any point, please let us know. All information will be kept strictly confidential and not shared. If you have any questions, please don't hesitate to ask.

PATIENT'S NAME (LAST, FIRST, M.I.) DATE OF BIRTH SEX AGE

HOME ADDRESS

w. ( ) _____ h. ( ) _____ c. ( ) _____
PHONE

MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

E-MAIL ADDRESS DRIVER'S LICENSE # DRIVER'S LICENSE STATE SSN

OCCUPATION EMPLOYER

YES NO Has any member of your family been treated in our practice? If yes, name of patient: _____

Who should we contact in case of emergency?

NAME PHONE RELATIONSHIP TO PATIENT

Primary Dental Insurance

NAME OF SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH EMPLOYER

NAME OF INS. COMPANY PHONE NUMBER OF INS. COMPANY CONTRACT NUMBER GROUP NUMBER

How did you hear about our office?

Newspaper/Magazine Ad Yellow Pages Friend or relative (please list name) _____

Internet Search/Website Mail Other (please specify) _____

Social Media (Facebook/Instagram) Community Event

I certify that all the information above is correct to the best of my knowledge. I agree to notify this office of any changes to the above information as soon as reasonably possible.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

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Patient Health History

PATIENT'S NAME _____ DATE OF BIRTH _____

MAIN DENTAL CONCERN FOR TODAY'S VISIT _____

Oral Health Circle yes or no.

YES NO Do you currently have any known dental problems?

YES NO Are any of your teeth sensitive to hot, cold, biting pressure, or sweets?

YES NO Do your gums bleed when brushing or flossing?

YES NO Have you ever been told you have periodontal (gum) disease?

YES NO Have you had a complete set of dental x-rays in the past year?

YES NO Do your jaw joints (TMJ) click, pop, or cause pain?

YES NO Do you clinch or grind your teeth?

YES NO Have you had your wisdom teeth removed?

YES NO Do your teeth show signs of chipping and wear?

YES NO Do you have a replacement of any type for missing teeth?

YES NO Have you ever had any unfavorable dental experiences?

YES NO Is there anything you would like to change about your smile? If so, please explain:

Medical Health

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

Circle yes or no.

YES NO Are you under the care of a physician now? If yes, please list reason(s): _____

YES NO Have you been hospitalized in the past 5 years? List reason(s): _____

YES NO Have you had any serious illnesses or operations? Please list: _____

YES NO Are you currently taking any medications, pills, or drugs? Please list: _____

_____

_____

YES NO Are you allergic to any medications or other substances? (Circle all that apply)

Aspirin Penicillin Other Antibiotics Codeine Anesthetics Metals Latex Other _____

YES NO Any Heart Problems

CONTINUED ON REVERSE

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

YES NO	Artificial Joints or Valves	YES NO	Cancer/Tumor	YES NO	Fainting Spells
YES NO	Pacemaker	YES NO	Excessive Bleeding	YES NO	Epilepsy/Seizures
YES NO	High Blood Pressure	YES NO	AIDS/HIV	YES NO	Thyroid Problems
YES NO	Low Blood Pressure	YES NO	Hepatitis	YES NO	Psychiatric Treatment
YES NO	Rheumatic Fever	YES NO	Kidney Disease		
YES NO	Stroke	YES NO	STDs		
YES NO	Diabetes	YES NO	Tuberculosis		

YES NO Do you have any disease, conditions, or condition not listed above? Please list: _____

YES NO Do you require antibiotic premedication for dental treatment?

Women: (Check if applicable) ☐ Pregnant (Due Date_____) ☐ Nursing ☐ Taking Birth Control

Is there anything else you would like for us to know about?_____

I certify that all the information above is true and correct to the best of my knowledge. I understand that an accurate medical and dental history is necessary to safely and completely treat my dental needs. I agree to let this office know as soon as possible if any of this information changes.

_____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed 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 January 1, 2014, 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 this 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 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.

CONTINUED ON REVERSE

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 officials 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 than 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 this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

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 Janury 1, 2014. 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 requests.

Restrictions: You have the right to request that we place additional restrictions on 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 handled 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.

Questions 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 or 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 this 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 the 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.

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Acknowledgment of Receipt of Notice of Privacy Practices

**You May Refuse To Sign This Acknowledgment*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
PATIENT NAME (PLEASE PRINT)

_____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN DATE

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice Of 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 acknowledgement
- ☐ Other (Please specify) _____

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Financial/Services Agreement

I acknowledge full responsibility for the payment for all my services rendered on my behalf or to any of my dependents. I understand that payment is due at the time of service. In the event payment is not received , I understand that an interest rate of 15% APR may be added to my account. I also understand that I am responsible for any fees Hazel Green Dental incurs collecting the balance on my account Collection companies, court costs, etc. I acknowledge that there is a cancellation fee as follows for any appointment cancelled with less than 24 hours notice (with the exception of emergencies).

Hygiene Appts: $25 *Dentist's Appts: $25 per half hour scheduled*

I hereby authorize payment directly to Hazel Green Dental of the group insurance benefits, if any, otherwise payable to me for services rendered.

I understand that filing insurance benefits for Hazel Green Dental's patients is a courtesy that this office is pleased to offer. This office currently accepts many insurance plans. I understand that insurance plans are ever changing, and that it is impossible for me to receive a guaranteed quote at the time of service. Because of this, I understand that my payment portion of services rendered is only an estimate, and that I may be required to pay the remaining charges not covered by my dental insurance plan.

I grant the right to the dentist to release my dental, medical, and other information about my dental treatment to third party payers and/or other health professionals, as appropriate under the circumstances and within the HIPAA guidelines. I hereby authorize the dentists or designated staff of Hazel Green Dental to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the dentist in order to make a thorough diagnosis of my dental needs and that these recordsmay be used for diagnostic and educational purposes.

Upon such diagnosis, I authorize the dentists at Hazel Green Dental to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, nitrous oxide, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a recital of any possible complications.

I hereby authorize the dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I have received a copy of the HIPAA Privacy Policy as required by law.

I grant the dental office permission to use the email address given to contact me with respect to my dental care.

I have read all the information on this agreement and understand each statement. I also authorize the use of this signature on all dental insurance submissions.

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HIPAA Disclosure

PATIENT NAME _____ DATE OF BIRTH _____

PARENT/LEGAL GUARDIAN _____

I, _____, hereby authorize Hazel Green Dental to release my information (appointments, diagnosis, treatments, financial, etc.) via phone, mail, fax, email, or in person, to the people listed below.

Please also indicate who may accompany the patient to their appointment if the patient in unable to drive themselves.

NAME _____ RELATIONSHIP _____ ☐ Release of information ☐ Accompany to Appointment

NAME _____ RELATIONSHIP _____ ☐ Release of information ☐ Accompany to Appointment

NAME _____ RELATIONSHIP _____ ☐ Release of information ☐ Accompany to Appointment

NAME _____ RELATIONSHIP _____ ☐ Release of information ☐ Accompany to Appointment

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NAME _____ RELATIONSHIP _____ ☐ Release of information ☐ Accompany to Appointment

NAME _____ RELATIONSHIP _____ ☐ Release of information ☐ Accompany to Appointment

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____