

New Patient Details

615 E 82nd Ave Suite 100 Anchorage, AK 99518 | (907) 562-1686



EMERALD PEAK
DENTAL

Patient Information

First Name		Last Name		Preferred Name		Sex
Date of Birth ___/___/___	Social Security Number		Driver License #		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Address			City		State	Zip Code
Email			Cell Phone		Home Phone	
Employer		Occupation		How long?		
How did you hear about us?						

For Minors ONLY: Person Responsible for Account

First Name		Last Name		Preferred Name		
Date of Birth ___/___/___	Social Security Number		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed		Phone Number	
Address			City		State	Zip Code

Emergency Contact

Contact Name	Relationship	Phone Number
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Insurance Information

Primary Dental Insurance

Insurance Company	Mailing Address	City		State	Zip Code
Phone Number	Policy Holder Name	Policy Holder Birthday	ID Number/Policy Holder SSN		
Group Number		Employer Name	Relationship to Patient		

Secondary Dental Insurance

Insurance Company	Mailing Address	City		State	Zip Code
Phone Number	Policy Holder Name	Policy Holder Birthday	ID Number/Policy Holder SSN		
Group Number		Employer Name	Relationship to Patient		

Health History

Do you have any of the following conditions?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes/Fever Blisters | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Sickle Cell Disease/Traits |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Osteoporosis/Paget's | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |

Please list any other medical conditions you may have:

Are you currently taking any prescription or over-the-counter medications? YES NO

If YES, please list each medication:

Do you require antibiotics prior to dental treatment? YES NO

Are you allergic to any of the following? YES NO

- | | | | |
|----------------------------------|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other: _____ |

Do you use tobacco or marijuana products? YES NO

Do you use any controlled substances? YES NO If YES, which one(s)? _____

Do you have any metal rods, pins, or implants? YES NO

Have you ever taken Fosamax or another bisphosphonate? YES NO

Have you been told that you snore or hold your breath while sleeping, or wake up gasping for air? YES NO



Dental History

What is the reason for your visit today? _____

Are you currently in pain? YES NO

Have you ever had a serious problem associated with previous dental work? YES NO

Do you have fears about going to the dentist? YES NO

Have you ever had gum treatment? YES NO

Do your gums ever bleed? YES NO

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? YES NO

Describe your current dental health: GOOD FAIR POOR

Do you like your smile? YES NO

How many days a week do you floss? _____ How many times a day do you brush? _____

Type of toothbrush bristles: SOFT MEDIUM HARD

How frequently do you replace your toothbrush? Every 1-3 months Every 6-9 months
 Every 3-6 months Every 9-12 months

Are your teeth sensitive to any of the following? HEAT COLD OTHER NONE

Do you have any missing teeth? YES NO If YES, how many? _____

For Women ONLY

Are you pregnant? YES NO If YES, please list your due date: _____

Are you nursing? YES NO

Are you taking birth control? YES NO

Acknowledgement & Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature of Patient or Responsible Party	Printed Patient Name	Date
Printed Name of Responsible Party (if applicable)	Relationship to Patient	

Financial Agreement

615 E 82nd Ave Suite 100 Anchorage, AK 99518 | (907) 562-1686



Our Financial Alliance

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

We continue our commitment to you by offering a variety of financial options to enable you to receive the dental care you need and desire. We accept cash, check VISA, MasterCard, Discover, and American Express. We have also partnered with the third-party companies CareCredit and Lending Club to offer the flexibility of deferred interest and extended payment options.

We will communicate all recommended treatment options and associated fees, prior to the start of treatment. Payment is expected at the start of treatment. Occasionally, unforeseen circumstances may necessitate additional treatment; if additional treatment is necessary, we will inform you as to its nature and cost before proceeding.

Regarding Insurance

*As a courtesy to our patients, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. As part of the financial arrangement process, we will **estimate** what your insurance will pay. We very much appreciate payment of your estimated patient portion upon receipt of services. We do not accept assignment of insurance benefits as a form of payment to help reduce your immediate out-of-pocket expense.*

- Dental insurance is a contract between the patient and the insurance company. It rarely pays for the entirety of your dental care – it is only meant to **assist** you with the costs. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.*
- It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer. Some services may not be covered. Our office is not aware of procedure or diagnosis codes that may not be covered by your specific dental benefits plan. **We are contracted (in-network) with Delta Dental Premier.** If we are not in-network with your plan, we are happy to investigate and review your dental benefits with you before you receive care. **We do not bill to Medicare or Medicaid.***
- The total fee for treatment is your responsibility, whether your insurance company pays or not. If your insurance company has not paid on your claim within 60 days, the full balance will be transferred to you. In the event that your insurance company denies payment of a service, or pays less than estimated, you are responsible for that fee. Any unpaid balance after insurance pays is due within **14 days.***

Thank you for understanding our Financial Alliance. Please let us know if you have any questions or concerns.

Acknowledgement

I have read and understood the above conditions and agree to accept full financial responsibility for any dental treatment fees incurred.

Signature of Patient or Responsible Party	Printed Patient Name	Date
Printed Name of Responsible Party (if applicable)	Relationship to Patient	

HIPAA Release Form

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EMERALD PEAK
DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices & Consent for Release of Information

You may decline to sign this acknowledgement

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

I authorize the release of my dental health information to the following people:

Full Legal Name

Relationship to Patient

Signature of Patient or Responsible Party

Printed Patient Name

Date

Printed Name of Responsible Party (if applicable)

Relationship to Patient

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 declined to sign*
- Communication barriers prohibited obtaining the acknowledgement*
- An emergency situation prevented us from obtaining the acknowledgement*
- Other:* _____

Notice of Privacy Practices

615 E 82nd Ave Suite 100 Anchorage, AK 99518 | (907) 562-1686



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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/30/2011 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes:

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. For example, 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.

To You or Your Personal Representative: 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 your personal representative, but only if you agree that we may do so.

Notice of Privacy Practices (continued)

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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information or 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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

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. We will provide copies of your records at no charge.

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 April 14, 2003. 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.



Notice of Privacy Practices (continued)

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation of 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 made in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this notice electronically or on our web site or by electronic mail (e-mail).

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.

Contact Office Manager: Nicole Edwards

Telephone: (907) 562-1686

Fax: (907) 563-6484

E-mail: nedwards@emeraldpeakdental.com

Address: 615 East 82nd Avenue Suite 100, Anchorage, AK 99518

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