TAYLOR DRIVE DENTAL CARE
TAYLOR DRIVE FACIAL AESTHETICS

1337 N. Taylor Dr. * Sheboygan, WI 53081 * Phone: 920-452-4688 * Fax: 920-452-4670

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.
***FOR THE PROTECTION OF PATIENTS AND STAFF, CAMERAS ARE IN USE.**

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH/FINANCIAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand I may revoke this authorization in writing at any time by contacting the practice at the address listed above, except to the extent that action has already been taken in reliance of this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. (Specify expiration date: _____).

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of TDDC via:

□ Phone Message ☐ **Any of the Above**
□ Text Message ☐ **None of the above** (opt out)
□ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

HIPAA made EASY™

TAYLOR DRIVE
DENTAL CARE

Elliot Humiston, MMP, DDS
Anastasia Zagordo, DDS

1337 N TAYLOR DRIVE * SHEBOYGAN WI 53081 * PHONE: 920-452-4688 * FAX: 920-452-4670

WELCOME

Today's Date _____ /_____ /_____
Age: _____

PATIENT REGISTRATION

How did you hear about our office? _____

Patient's Name: _____Date of Birth: ___/__/___ M☐ F☐
First M.I. Last

If Child: Parent's Name_____
How do you wish to be addressed? _____
Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

Patient's Address_____Apt/Lot#_____City: _____State: _____ Zip: _____
Primary phone number: _____ Home ☐ Work ☐ Cell ☐
Secondary number: _____ Home ☐ Work ☐ Cell ☐
Email address: _____
Is patient employed: ☐ Yes ☐ No Employer_____
Employment status:

Full Time ☐	Part Time ☐	Self Employed ☐
Student ☐	Active Military ☐	Retired ☐

Who is **legally responsible** for the patient's dental healthcare decisions?
Self ☐ Parent ☐ Kinship ☐ Guardian ☐ Power of Attorney ☐ Case Worker ☐

Name: _____ Phone Number: _____
Address, City, State, Zip:_____
Preferred Method of Communication: ☐Telephone ☐Email_____
Patient lives at: ☐Personal Home ☐Facility/Group Home ☐Other_____
***Please provide a copy of the custodial order documentation.** *For example: Guardianship order, POA Health Care Agent designation, Medical Service Consent, etc.*

Insurance Information ☐ I CURRENTLY DO NOT HAVE DENTAL INSURANCE

Primary Insurance Coverage:
Name of employer: _____
Name of insurance company: _____
Group/Policy #: _____
Member ID #: _____
****If policy holder is someone other than patient, please complete the following information:***
Subscriber of insurance: _____
Subscriber Date of Birth: _____/_____/_____
Subscriber Social Security Number: _____/_____/_____

*PLEASE CONTINUE ONTO OTHER SIDE ⟹

Secondary Insurance Coverage

Name of employer: _____

Name of insurance company: _____

Group/Policy #: _____

Member ID #: _____

*_**If policy holder is someone other than patient, please complete the following information:**_

Subscriber of insurance: _____

Subscriber Date of Birth: _____/_____/_____

Subscriber Social Security Number: _____/_____/_____

_____

CONSENTS/FINANCIAL RESPONSIBILITY: _**-Please Initial-**_

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. _____

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent of disclosure of records shall be effective until I revoke it in writing. _____

I authorize payment directly to the dentist or dental group, any insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of the dental benefits may pay less than the actual bill for services, and ***I am financially responsible for payment in full of all accounts***. By Signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. _____

I understand that I am responsible for notifying the dental office of any changes in my insurance/additional insurance that I may have. Failure to do so will result in unfiled claims. We file this on your behalf to your insurance company as a courtesy to you. Should you not inform us, it will then become ***your*** responsibility to file any further claims associated with that service on your own. We ***do not*** submit to **MEDICAL** insurance. _____

WEIGHT RESTRICTIONS: Due to weight limits/restrictions on dental chairs & for our patient's safety, I understand I must inform Taylor Drive Dental Care if my weight exceeds 300lbs. _____

CANCELLATION POLICY:

Due to the high demand for appointments, our practice requires ***at least*** a 24-hour notice to change/cancel an appointment. If you miss an appointment or cancel less than the required 24-hour notice, you will be charged a non-refundable $50 fee. This will need to be paid prior to making another appointment. Should 2 missed appointments occur within a 12-month period, a *warning letter* will be sent. ***We will make every effort to work with you to help you make your appointment. We know life happens.

If a 3rd missed appointment occurs, a dismissal letter will be sent, stating patient will be seen for emergencies only for 30 days. We will be happy to forward records to a new dental home. _____

*****WORKMAN'S COMP:** If your dental care is a result of a work injury and will be billed to your workman's comp insurance, *please notify* our team. We will gladly file your claim on your behalf; however, **the full balance of care is due at time of service.** Any workman's comp *reimbursements* would be *sent directly to you*.

All co-pays are asked for at the time of services. If ***any*** payment arrangements need to be made, please speak with our financial coordinator ***prior*** to your appointment date. 3rd party financing is available through CareCredit and Cherry.

I attest to the accuracy of the information on this form.

PATIENT'S OR GUARDIANS SIGNATURE:

_____

DATE: _____

CareCredit Making care possible...today. Cherry

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Today's Date: _____
Name: _____**DOB:** _____ **Male** ☐ **Female** ☐
Purpose of today's visit: _____

Are you under a physician's care now? Yes No If yes, _____
Have you ever been hospitalized or had a major operation? Yes No If yes, _____
_____
Have you ever had a serious head or neck injury? Yes No If yes, _____
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, _____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? Yes No
If yes, _____
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No If yes, _____
Women: are you…
Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to *any* of the following?
Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐

Sulfa Drugs ☐ Local Anesthetics ☐ Other? _____
If yes, _____
Are you taking any medications? If yes, please list or provide medication(s) list to our team. _____
_____
_____

_____

Do you have any of the following?

AIDS/HIV Positive	Yes	No	Easily Winded	Yes	No
Alzheimer's Disease	Yes	No	Emphysema	Yes	No
Anaphylaxis	Yes	No	Epilepsy or Seizures	Yes	No
Anemia	Yes	No	Excessive Bleeding	Yes	No
Angina	Yes	No	Fainting Spells/Dizziness	Yes	No
Arthritis/Gout	Yes	No	Frequent Cough	Yes	No
Artificial Heart Valve	Yes	No	Frequent Headaches	Yes	No
Artificial Joint	Yes	No	Glaucoma	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No
Blood Disease	Yes	No	Heart Attack/Failure	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No
Breathing Problems	Yes	No	Heart Pacemaker	Yes	No
Bruise Easily	Yes	No	Heart Trouble/Disease	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No
Chemotherapy	Yes	No	Hepatitis A, B, or C	Yes	No
Chest Pains	Yes	No	Herpes (Genital)	Yes	No
Cold Sores/Fever Blisters	Yes	No	Herpes (Oral)	Yes	No
Congenital Heart Disorder	Yes	No	High Blood Pressure	Yes	No
Convulsions	Yes	No	High Cholesterol	Yes	No
Diabetes	Yes	No	Hives or Rash	Yes	No
Drug Addiction	Yes	No	Hypoglycemia	Yes	No

Irregular Heartbeat	Yes	No	Sickle Cell Disease	Yes	No
Kidney Problems	Yes	No	Sinus Trouble	Yes	No
Leukemia	Yes	No	Sleep Apnea C-PAP Machine	Yes Yes	No No
Liver Disease	Yes	No	Spina Bifida	Yes	No
Low Blood Pressure	Yes	No	Stomach/Intestinal Disease	Yes	No
Lung Disease	Yes	No	Stroke	Yes	No
Mitral Valve Prolapse	Yes	No	Swelling of Limbs	Yes	No
Osteoporosis	Yes	No	Thyroid Disease	Yes	No
Pain in Jaw Joints	Yes	No	Tonsillitis	Yes	No
Parathyroid Disease	Yes	No	Tuberculosis	Yes	No
Psychiatric Care	Yes	No	Tumors or Growths	Yes	No
Radiation Treatments	Yes	No	Ulcers	Yes	No
Recent Weight Loss	Yes	No	Venereal Disease	Yes	No
Renal Dialysis	Yes	No	Yellow Jaundice	Yes	No
Rheumatic Fever	Yes	No			
Rheumatism	Yes	No			
Scarlet Fever	Yes	No			
Shingles	Yes	No			

Have you ever had any serious illness not listed above? Yes No If Yes,

_____

_____

Have you ever had Botox/Fillers? Yes No If Yes, _____

_____

Height: _____Weight: _____

Dental History:

Last Dental Visit:			Do you wear DENTURES?	**Y**	**N**	If **YES**, ☐Partial(s) ☐Denture(s) Are you interested in replacements? **Y N**
Do you have Dental Anxiety?	**Y**	**N**	Do you have chronic Hoarseness?	**Y**	**N**	
Current Dental Concerns? If YES, please explain:	**Y**	**N**	How often do you BRUSH? ☐ Daily x_____ ☐ Weekly x_____ ☐ Rarely ☐ Never			
Are you currently in PAIN?	**Y**	**N**	Do you FLOSS?	**Y**	**N**	
Do your gums BLEED?	**Y**	**N**	If you floss how often?			
Do you CLENCH OR GRIND?	**Y**	**N**	Do you regularly drink:			
Do have or had BRACES?	**Y**	**N**	Soda **Y N**	Energy Drinks **Y N**		
Do you Snore?	**Y**	**N**	Juice **Y N**	Other		

If you could change ANYTHING about your smile, what would it be?

_____

Are you interested in Whitening? _____ Are you interested in Invisalign? _____

Are you interested in Sedation? _____

Whom should we contact in case of emergency?

Emergency Contact: _____ Relationship _____ Phone: _____

Preferred Pharmacy Name & Location: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature: _____ Date: _____

***DENTIST SIGNATURE*: _____ *DATE*: _____**