PATIENT INFORMATION

Patient Name: _____ **Social Security Number** _____

Date of Birth (MM/DD/YYYY): _____ **Sex: Male / Female**

Address: _____

_____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-mail Address: _____

Would you be interested in having communications sent to you via your e-mail address? **YES / NO**

*Examples: appointment reminders, administrative updates and health bulletins

How did you hear about our Practice?

( ) Family/ Friends: Name_____ ( ) Google/Internet Search ( ) Passing by

( ) Through Zocdoc ( ) Through Insurance Carrier ( ) Other: _____

Person responsible for payment and Insurance Information

Guarantor Name: _____

Social Security Number: _____

Insurance Name: _____

Group #: _____ Member ID #:_____

Insurance Address: _____

Relationship to Patient: (please check): ( ) Self, ( ) Spouse, or ( ) Parent

Date of Birth (MM/DD/YYYY): _____ Sex: Male / Female

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone Number: _____

Who to call for an emergency:

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMIBILE ACCIDENT? **YES / NO**
IF YES, PLEASE NOTIFY THE RECEPTIONIST.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Evergreen Dental, LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

_____ _____

Patient / Guardian Signature ***Date***

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Name of Medical Doctor: _____ City/State/Zip: _____

Emergency Contact: _____ Relationship: _____

List all Medications or drugs you are currently taking: ( ) None

_____

Check medications or drugs you are ALLERGIC to:

( ) None
( ) Aspirin
( ) Codeine/ other narcotics
( ) Erythromycin
( ) Latex
( ) Local Anesthetics
( ) Metals
( ) Penicillin
( ) Sulfa Drugs
( ) Other: _____

Women: Are you…

( ) Pregnant / Trying to get pregnant?
( ) Nursing?
( ) Taking oral contraceptives?

Check any Medical Conditions you may have:

( ) None
( ) AIDS / HIV
( ) Alcohol / Drug Abuse
( ) Anemia / Leukemia
( ) Anorexia / Bulimia
( ) Arthritis
( ) Asthma / Hay fever
( ) BLOOD Clotting Problems
( ) Bronchitis
( ) Cancer / tumor or growth
( ) Cardiac Pacemaker
( ) Chest pain
( ) Damage Heart Valve
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Fainting Spells / Seizures
( ) Fever Blisters / Herpes
( ) Frequent Headaches
( ) Frequently Dry Mouth / Sjogren
( ) Gall Bladder Trouble
( ) Heart Attack / Stroke
( ) Heart Disease / Angina
( ) Hepatitis / Jaundice
( ) High Blood pressure
( ) Hives / Skin Rash
( ) Joint replacement, Date: _____
( ) Kidney / Bladder Trouble
( ) Liver Disease
( ) Low Blood Pressure
( ) Mental Health Problems
( ) Mitral Valve Prolapse
( ) Rheumatic fever
( ) Rheumatic Heart Disease
( ) Sinus Trouble
( ) Thyroid Problems
( ) Tuberculosis
( ) Other: _____

Tobacco use? If so what kind and how much? _____

Unusual reaction to DENTAL injections? _____

Reason for today's visit: _____

NEW PATIENT:

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

By signing below, I certify all of the above information is true to the best of my knowledge.

Patient / Guardian Name (PRINTED): _____ ***Date***: _____

Patient / Guardian Signature: _____

Doctor Signature: _____

OUR OFFICE FINANCIAL POLICY

Thank you for choosing Evergreen Dental, LLC for your family's dental needs. We are committed to providing you with affordable and excellent dental care. Your trust is very important to us so our goal is to make sure you fully understand your treatment needs and financial responsibility before treatment begins. We will make every effort to work with you to ensure that your dental needs can be met.

PAYMENTS

Payment is expected at the time of service unless prior financial arrangements have been made. We offer several options:

1. Patients with insurance: co-pays, deductibles, and/or portion not covered by insurance are due at the time of treatment.
2. Patients without insurance: all payments for dental services rendered are due at the time of service.
3. We accept Visa, MasterCard, Discover and American Express.
4. Evergreen Dental, LLC has partnered with CareCredit, a patient financing company, to offer our patients 0% interest financing for 6 or 12 months with approval. No other payment plans are available.
5. There will be a minimum 60% down payment required at the time of service for any dental procedure that requires the service of a laboratory (crowns, bridges, dentures, etc.)

PATIENTS WITH DENTAL INSURANCE

As a courtesy to our insured patients, we will be happy to help file your dental insurance claims. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. Although we agree to charge our fees to you based on your insurance fee schedule and help you file the claim, we are not a party to your insurance contract. Therefore, any payment that is not received from your insurance after 60 days from the treatment day will be due in full from you. You will then have to obtain reimbursement directly from your insurance company. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

MISSED APPOINTMENTS

Dr. Andy Huh reserves your appointment time exclusively for you. Your reserved time in our office is important. We understand that sometimes it is necessary to change your appointment so **we ask that you kindly give us a minimum of 1 business day notice**. Without this notice, we are unable to offer treatment to other patients that may have needed our care. If 2 or more appointments are broken in a 12 month period without 1 business day notice, all future appointments will be cancelled and patients will be placed on a "priority list" for their next visit.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy.

Patient / Guardian Signature: ***Date:***

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

**Please read and initial the items below and sign at the bottom of the form.*

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventative Services _____ Restorations _____

Crowns _____ Bridges _____ Other _____ Patient Initials _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient Initials _____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

_____ _____

Patient / Guardian Signature ***Date***

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY SEND HEALTH INFORMATION ABOUT YOU

Your protected health information ("PHI") includes information relating to your mental or physical health and to the health care provided to you, including materials like your dental records, dental x-rays, and payment records. Some documents containing PHI may include such sensitive personal information as a Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse records, positive HIV status, and other kinds of sensitive information.

Sometimes our dental practice needs to send PHI to the patient or to someone else, such as a specialist. There are various ways to send PHI, including email and other electronic means. Our dental practice does not encrypt email or other electronic forms of communication.

There is a risk that unencrypted information may be acquired by hackers or received by unintended recipients. If you are concerned about the security of PHI that may be sent unencrypted, please let us know and we will send it a different way, which may include providing the information to you to deliver.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations.

Treatment: We may disclose your health information to a specialist providing treatment to you.

Payment: Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: Healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official.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 the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically 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 if 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.

Evergreen Dental, LLC

790 Boston Rd Unit 205
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Telephone: 978-362-3181
Fax: 978-362-8791
E-mail: hello@evergreendmd.com

ACKNOWLEGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I _____, have read and received a copy of the office's Notice of Privacy Policies.

_____

Patient Name (printed)

_____ _____

Signature of Patient (Guardian) ***Date***