PATIENT INFORMATION

Name____Today's Date__________________________

Home______________________ Cell______________________ E-mail______________________________

Address____City/State__________________Zip Code__________

Sex M F Marital Status Married Single Patient DOB_____________ Age_____ Adult Minor

How did you hear about us? Newspaper Office Sign Website Yellow Pages Billboard Family/Friend

Whom may we thank for referring you? ____

Person Responsible for Account/Relationship____

SSN______ _____ ______ DOB_________________ Please Present Driver's License To Be Copied

Patient Employer________________________________ Employer's Phone _________________________

Emergency Contact______________________________ Phone #__________________________________

PRIMARY INSURANCE

Insurance Company Name____Phone#__________________

Address______________________________City/State__________________Zip Code_______________

Subscriber's Name____DOB_____________________

Subscriber's ID or SSN_____________________Group #______________ Individual Plan Family Plan

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance with ____________________________________and assign directly to Dr. Novikov all insurance benefits, in any, otherwise payable to me for the services rendered. **I understand that I am financially responsible for all charges, whether covered by insurance or not, and that payment is due on the date of service unless prior arrangements have been made.** I authorize the use of my signature on all claim submissions. The above named doctor may use my health care information and disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment and determining insurance benefits or the benefits payable for the related services.

____ ________________________

Signature of patient, parent or guardian Date

____ ________________________

Please print name of patient, parent or guardian Relationship to patient

HEALTH HISTORY

Patient Name ______________________________ Today's Date ____________

Are you under physician's care? Yes No Date of last visit____________

Physician's Name______________________________ ____________________

Have you had any serious illnesses or operations? Yes No

If "Yes", please list____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? Yes No

Have you ever received Biophosphate Therapy (Fosamax, Actonel, etc.)? Yes No

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? Yes No

Do you take blood thinners? Yes No Are you Pregnant? Yes No Nursing? Yes No

Check (√) if you have or have had any of the following:

Arthritis, Rheumatism	Diabetes	Hemophilia	Pacemaker
Artificial Heart Valves	Epilepsy	Hepatitis	Radiation Treatment
Artificial Joints	Fainting	High Blood Pressure	Respiratory Disease
Asthma	Glaucoma	HIV/AIDS	Rheumatic Fever
Back Problems	Headaches	Kidney Disease	Stroke
Blood Disease	Heart Murmur	Liver Disease	Thyroid Problems
Cancer	Heart Problems	Mitral Valve Prolapse	Osteoporosis

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

Please explain: ____

MEDICATIONS

List all medications you are currently taking: ______________________________

Pharmacy Name______________________________ ____________________

ALLERGIES

Aspirin Barbiturates Codeine Latex Penicillin Sulfa Other____________________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Signature______________________________ Date____________________

DENTAL HISTORY

Patient Name ______________________________ Today's Date ____________

Reason for Today's visit ______________________________ Date of last dental care ____________

Former Dentist ____________________ ☎ ____________ Date of last dental x-rays ____________

Are you especially anxious or fearful about dentistry? Yes No ______________________________

Do you wear retainers, night guard or other appliance? Yes No ______________________________

Do you use tobacco products? Yes No ______________________________

Check if you have had problems with any of the following:

Bad Breath	Grinding Teeth	Sensitivity to hot
Bleeding Gums	Loose teeth or broken fillings	Sensitivity to sweets
Clicking or popping jaw	Periodontal treatment	Sensitivity when biting
Food collection between teeth	Sensitivity to cold	Sores or growths in your mouth
Jaw Pain	Snoring Problems	Sleep Apnea

How would you rate your oral health (1-10)? _____

HOME CARE

How often do you floss? ____________________ How often do you brush? ____________________

Toothbrush: Electrical: Oral-B____ Sonicare______ Other_____

Manual: Soft______ Medium______ Hard_____

Toothpaste ________________ Mouth rinse ________________ Whitening Products ____________

Waterpik Yes No Other dental homecare products? Yes No

APPEARANCE

Are you happy with your smile? Yes No If "No", please explain ______________________________

____

Are you happy with the color of your teeth? Yes No

I am interested in: Brighter teeth Straight teeth Porcelain Veneers Dental Implants

We want you to feel comfortable with the dental care you receive, as well as our fees and payment arrangements. Please do not hesitate to discuss your treatment plan, fees and financial arrangements with us if you have any questions.

Our Policies

Insurance

As a courtesy to you, we will file your insurance. We will work with you and your insurance company, to the best of our ability, to maximize your dental benefits. If your insurance company allows you to assign benefits, we will accept payment directly from the insurance company. **We do require, however, that you pay your portion of the total at the time of service.**

Please understand that although we will submit your claim for you, **the responsibility for collection from your insurance company is ultimately yours.** Payment of any amount not covered by insurance is your responsibility.

____ **Please initial**

Payment Policy

Payment is expected at the time of service. There is a $35.00 charge for all returned checks. For you convenience, we accept Visa, MasterCard and Discover.

If you do not pay on your account within 90 days it will be turned over to a collection agency. When your account is turned over to a collection agency, you are responsible for all related fees. All fees must be paid before your next appointment.

____ **Please initial**

Broken Reservation Policy

We strive to give professional, personalized care to each of our patients. We do not "overbook" our schedule. When reserved time is missed or cancelled on short notice, it not only affects you, but also the other patients waiting to be seen, as well as Dr. Novikov and his entire staff. For this reason there will be a $53.00 fee per hour scheduled for missed reservation without a 24 hour notice.

____ **Please initial**

Working Together

Our financial coordinator is available to answer your questions about fees, billing and financial arrangements. She is happy to respond to concerns regarding dental charges and will make every effort to arrange mutually satisfactory financial arrangements with us. Thank you.

I have read the above, understand it, and agree with it.

Signature of patient (or guardian)______________________________ Date____________

Printed Name____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Cross City Dental
PO Box 2059
Cross City, FL 32628
(352)498-7001

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________ Date: ______________________

Signature: ______________________________

Relationship to Patient: ______________________

Dependent family members also covered by this acknowledgement:

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. . . .

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

The health Insurance Portability Act of 1996 (HIPPA) requires that all health care records and other individually identifiable health information used of disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example we may need to share information with other health care providers of specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.

Heal Care Options include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help you with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect or domestic violence. Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have certain rights in regard to your protected health information, which you can exercise by presenting a written request to our privacy officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may, however, deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment or health care operations…or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of 1 January 2009, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. Revisions to our Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health& Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, contact:
Privacy Officer: Cindy Chewning
Office Name: Cross City Dental.
Address: PO Box 2059
Cross City, FL 32628
Phone: (352)498-7001

For more information about HIPPA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
(877)696-6775 (toll free)