Atkinson Dental

130 Court Street South
Vale, Oregon 97918
541-473-9166 Fax 541-473-9344

PATIENT INFORMATION

NAME_____ SEX: M F

ADDRESS_____CITY_____ STATE_____ ZIP_____

BIRTHDATE_____ AGE_____ MARITAL STAUS: M / S / W / D SOCIAL SECUIRTY # _____-_____-_____

DRIVERS LICENSE #_____ HM #_____ WK #_____ CELL # _____

EMAIL_____ PREFERED METHOD OF CONTACT _____TEXT _____ EMAIL _____ CALL

EMPLOYER_____ JOB TITLE_____ SUPERVISOR_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SPOUSE'S NAME_____ EMPLOYER _____DOB ___/___/____ S.S.# _____-_____-_____

CONTACT PERSON IN CASE OF EMERGENCY (NOT LIVING IN YOUR HOUSEHOLD)

NAME_____ RELATIONSHIP_____ HM #_____ WK # _____

PRIMARY INSURANCE INFORMATION

POLICY HOLDER_____ SELF / SPOUSE / PARENT SOCIAL SECUIRTY # _____-_____-_____

BIRTHDATE_____/_____/_____ EMPLOYER_____ JOB TITLE_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

INS COMPANY NAME_____ POLICY / ID#_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

SECONDARY INSURANCE INFORMATION

POLICY HOLDER_____ SELF / SPOUSE / PARENT SOCIAL SECUIRTY # _____-_____-_____

BIRTHDATE_____/_____/_____ EMPLOYER_____ JOB TITLE_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

INS COMPANY NAME_____ POLICY / ID#_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

REASON FOR TODAYS VISIT _____

FORMER DENTIST_____ CITY/STATE_____ DATE OF LAST VISIT_____DATE OF LAST XRAYS_____

[ ]BLEEDING GUMS	[ ]BLISTERS ON LIPS OR MOUTH	[ ]CLICKING OR POPPING JAW	[ ]DRY MOUTH
[ ]FINGERNAIL BITING	[ ] GRINDING TEETH	[ ]SENSITIVITY WHEN BITING	[ ]SENSITIVITY TO SWEETS
[ ] JAW PAIN/TIREDNESS	[ ]MOUTH PAIN	[ ]PERIODONTAL TREATMENT	[ ]SENSITIVITY TO COLD
[ ]SENSITIVITY TO HEAT	[ ]SWOLLEN/ TENDER GUMS	[ ]BAD BREATH	[ ] LIP/CHEEK/ MOUTH BITING
[ ]LOOSE TEETH OR BROKEN/LOST FILLINGS		[ ]SORES/GROWTHS IN MOUTH	[ ]FOOD COLLECTION BETWEEN TEETH

HOW OFTEN DO YOU FLOSS?_____ HOW OFTEN DO YOU BRUSH? _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PLEASE REFER TO OUR OFFICE! FOR REFFERING NEW CLIENTS YOU RECEIVE $25 CREDIT TO YOUR ACCOUNT!

Time 11:22 AM | DR. JACOB L. ATKINSON | Date 8/22/2016

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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
Are you taking any medications, pills, or drugs?	○ 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	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X Date:_____

Atkinson Dental
130 Court Street South
Vale, Oregon 97918
541-473-9166 Fax 541-473-9344

OUR FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our goal is to help you attain good oral health by providing quality dental care in a comfortable environment. Please understand that payment of your bill is an important part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Payment Policy

Payment is due at the time of treatment, unless previous arrangements have been made. We accept cash, checks and most major credit cards. We also accept Care Credit and have applications on hand to help assist in applying for credit.

Insurance

We accept most Dental Insurance Plans. With the insurance information you provide, our office staff can usually estimate what your portion or co-pay will be. YOUR PORTION IS DUE AT TIME OF SERVICE. As a courtesy, your insurance company will be billed for the balance. Any amounts which become more than 60 days past due with your insurance company will then be due by you. Any balance due by you for more than 60 days will incur an 18% per annum service charge and it will be up to you to collect from the insurance company. It is important to remember that you are ultimately responsible for the balance due and should there be a problem or you reach your benefit limit with the insurance company. Estimated insurance is only an ESTIMATED amount and is not a guarantee of benefits.

Payment Plans

We can assist you in obtaining financing through selected finance companies. Any agreement made between you and a financing company will be solely between you and the financing party.

Statements and Finance Charge

If you have an outstanding balance, you will receive a statement. Any portion due by you for more than 60 days after treatment (90 days after treatment in the case of an unpaid balance by insurance company) will be charged a 18% per annum service charge. After 90 days a collection fee of 25% will be charged on any bad debt sent to a collection company.

SIGNED:_____ DATE:_____

JACOB ATKINSON, D.M.D

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 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 November 8, 2016, 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 in formation 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 may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment:
We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment:
We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. 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:
We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

To Your Family and Friends:

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 under certain circumstances.

Appointment Reminders:
We will 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 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.

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 (email).

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.

Contact Officer: Hillary Morales, Office Manager Email: hillary.atkinsondental@gmail.com
Telephone: (541) 473-9166 Fax: (541) 473-9344
Address: 130 Court Street South Vale, Oregon 97918

JACOB ATKINSON, D.M.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

I,_____, have received a copy of ATKINSON DENTAL'S Notice of Privacy Practices today, _____/_____/_____.

(Please Print Name)

(Signature)

_____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)