Clear Lakes Dental
Registration Form

Last Name _____ First Name _____ M ____ DOB ___/___/_____
Address _____ Gender: _____
City _____ State _____ Zip Code _____ SSN: _____ - ____ - _____
Phone Number (_____) _____ - _____ ❑ **CALL or** ❑ **TEXT** ❑ **Married or** ❑ **Single or** ❑ **Child**

Email: _____ **How did you hear about us? _____**

Emergency Contact Information:
Name**:** _____ Phone Number**:** _____ Relationship**:** _____

For Minors ONLY (17 years old and under):
Parent/Legal Guardian's Name**:** _____ Phone Number**:** _____
(Person responsible for account)

Medical History: Do you have or have had any of the following? (Check all that apply)

- ❑ Acid Reflux
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Chemical Dependency
- ❑ Circulatory Problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Problems
- ❑ Hemophilia
- ❑ Hepatitis A B C
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Mental Health Disorders
- ❑ Migraines
- ❑ Pacemakers
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Rheumatic Disorders
- ❑ Sinus Problems
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tobacco User
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Venereal Disease
- ❑ Cancer: _____
- ❑ Other: _____
- ❑ **NONE of the above**

Are you allergic to any of the following? (Circle all that apply)

Penicillin Tetracycline Aspirin Erythromycin Codeine Dental Anesthetics Latex **NO Allergies**

Other Allergies**:** _____
Medications you are currently taking**:** _____
_____
Primacy Physician Name / Clinic / Phone Number: _____
Are you currently under the care of a physician? Yes / No

WOMEN: Are you pregnant? **Yes / No** If yes, how many weeks? ____ Nursing? **Yes / No** Taking birth controls? **Yes / No**

Last Dental Clinic/Visit _____ Reason for Visit Today _____
Any problems associated with dental work? Yes / No If yes, please explain _____
How many times do you brush each day? _____ How many times do you floss a week _____
Current Dental Health**:** [Excellent] [Good] [Fair] [Poor] **(Please circle one)**

Patient OR Parent/Legal Guardian's Signature _____ Today's Date _____

Turn to page 2 on the back*

Clear Lakes Dental
Office Policies

We ask for your consideration and cooperation in scheduling your appointments. We are partners in your dental care and we are committed to offering you appropriate care when you need it. Please understand that when you forget, cancel, or reschedule your appointment within the proper 24 hour notice, we miss the opportunity to fill that appointment time and clients on our waitlist miss the opportunity to receive services. It is mutually understood that if a cancellation is due to circumstances beyond any control, such as unfortunate incidence or unsafe weather conditions, these emergencies will be considered on an individual basis.
As a courtesy, our office confirms appointments two days in advance either by a phone call or text messaging. We must have confirmation from you no later than 3pm the business day before your appointment. If you are unable to contact us during business hours, please leave a message and we will get back to you.

Confirming your appointment is your responsibility. Thank you for supporting our cancellation policy.
If we do not receive confirmation from you, your reserved time may be cancelled to accommodate patients for dental emergencies.

After three (3) failed appointments, you will be considered a walk-in only patient. We will see you for your dental needs only when a provider is available.

Arriving 15 minutes or later does not allow time for a full assessment. Therefore, there is no guarantee you will be seen. You may wait for same day availability to be seen.

We require both a government Photo ID and insurance card at the time of appointment. For all children 17 and younger we require a parent/guardian government issued Photo ID. We will not be able to provide services to you if it is not available.

Initial _____

Child Supervision

Children 17 and under must be accompanied by a parent or guardian at all times within the treatment area. Only the child receiving treatment may enter the treatment area unless contained in a stroller or equivalent. Children remaining in the waiting area must be under the supervision of a qualified adult. Failure to adhere to any of the above where a child is not adequately supervised may necessitate termination of treatment and rescheduling of dental procedure(s).

Initial _____

Assignment of Benefits

I hereby request payment of authorized benefits to be made directly to Clear Lakes Dental for the services provided to me at this facility or any other facility owned and operated by Clear Lakes Dental.

Initial _____

Release of Records

I hereby authorize Clear Lakes Dental to release any information to the insurance company, including but not limited to diagnosis and records of treatment concerning my dental health and treatment.
I understand that Clear Lakes Dental will not release any information to anyone unless a release form is completed and returned to the facility by any means (fax, email, courier, etc.)

Initial _____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices (HIPAA) and have been provided an opportunity to review it.

Initial _____

Payment of Account

I acknowledge and understand that I am responsible for all charges for services rendered to me. Further, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable amount of time. If, for any reason, any portion of my bill is not paid by my insurance carrier, I agree to make arrangements for prompt payment. If any over-payment occurs, the amount will be credited to the account. I also know that it is my right to request for any reimbursement that may be owed.

Initial _____

I have read and understand all of the above policies.

Patient OR Parent/Legal Guardian Signature: _____ **Date:** _____

Clear Lakes Dental

Information Sharing Consent Form

I, _____, give my permission to share information concerning:

- My dental treatment
- The costs and financial arrangements for my dental treatment
- My personal health information
- Other

I give my permission to share the above noted information with:

- My spouse (name & DOB)_____
- My parent(s) (name & DOB)_____
- My adult child or children (name & DOB)_____
- Other _____

_____

Signed Date

❑ **I do not wish to share any information with anyone**

_____

Signature Date

CLEAR LAKES
DENTAL

NOTICE OF PRIVACY PRACTICES

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical records
- You can ask to see or get an electronic or paper of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (i.e., home or office phone) or to send mail to a different address.
- We will say "yes" to all the reasonable requests.

Ask us to limit what we use or share
- You can ask us NOT to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for the six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as and you asked us to make). We'll provide one accounting a year for fee but will charge a reasonable, cost-based fee if you ask for another within 12 months.

Get a copy of this privacy note
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has his authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at top of page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling 1-877-696-6775, visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends or others involved in your care.
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts
  If you are not able to tell us your reference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we NEVER share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you
- We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health.*

Run our organization
- We can use and share your health information to run our practice, improve our care and contact you when necessary.
  Example: we use your health information about you to manage your treatment services.

Bill you for services
- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: we give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information you can visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public and safety issues

We can share health information about you for certain situations such as:
- Preventing diseases
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with an organ procurement organization.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:
- For worker's compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such a military, national security, and presidential protective services.

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information you can visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes of the Terms of This Notice

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

02/28/2018