LANCE OSBORNE DENTISTRY

245 Van Asche Drive
Fayetteville, Arkansas 72703
(479)442-4051

Patient Information

Patient Name: _____ Date: _____
Last First Mi Preferred

Gender(M/F): ___ Marital Status: _____ Birth Date: _____ Social Security #_____

Driver's License#: _____ E-Mail Address: _____
State

Address: _____
Street

_____
City State Zip Code

Phone #'s: Home: _____ Cell: _____ Work: _____ Other: _____

Referral Information

How did you hear about us? Name of person, office or other source referring you to our practice:

_____

Spouse or Responsible Party Information

Name: _____ Date: _____
Last First Mi Preferred

Gender(M/F): ___ Marital Status: _____ Birth Date: _____ Social Security #_____

Driver's License#: _____ E-Mail Address: _____
State

Address: _____
Street

_____
City State Zip Code

Phone #'s: Home: _____ Cell: _____ Work: _____ Other: _____

(FRONT & BACK)

Employment Information

The following is for: ☐ The Patient ☐ The person responsible for payment

Employer name: _____

Address: _____
Street City State Zip code

Insurance Information

Primary Insurance Information:

Name of POLICY HOLDER: _____
Last First Mi Preferred

Policy holder's DOB: _____ ID #: _____ Group #: _____

Policy holder's employer name: _____

Address: _____
Street City State Zip Code

Patient's relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) _____

Insurance Plan Name & Claims Address:_____

_____
Street City State Zip Code

Secondary Insurance Information (if applicable):

Name of POLICY HOLDER: _____
Last First Mi Preferred

Policy holder's DOB: _____ ID #: _____ Group #: _____

Policy holder's employer name: _____

Address: _____
Street City State Zip Code

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) _____

Insurance Plan Name & Claims Address: _____

_____
Street City State Zip Code

(FRONT & BACK)

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Dental Health History

Patient Name: _____ Date: _____ Birth Date: _____
Last First

Dental History

Reason for today's visit: _____

Former Dentist: _____

Address: _____
Street

_____
City State Zip Code

Date of last dental care: _____ Date of last x-rays: _____

Please check if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Oral sores or growths
- ☐ Oral habits e.g. thumb sucking

Have you ever heard of MYO Functional Therapy? YES NO

Medical History

Physicians name: _____ Date of last visit: _____

Have you had any serious illnesses or operations? Please circle **YES NO**

If yes, please describe_____

Have you ever had a blood transfusion? Please circle **YES NO**
If yes, please give approximate date: _____

(FRONT & BACK)

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Please circle **YES NO**

(Women) Are you pregnant? **YES NO** Nursing? **YES NO** Taking birth control pills? **YES NO**

Please check if you have had or have any of the following: (even if not diagnosed by a physician)

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Asthma
- ☐ Back problems
- ☐ Bedwetting
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough
- ☐ Difficult birth delivery/nursing
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Heart conditions
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Respiratory
- ☐ Shortness of breath
- ☐ Skin rash e.g. eczema, psoriasis
- ☐ Stroke
- ☐ Swelling of feet/ankles
- ☐ Thyroid condition
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Trouble sleeping
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal disease
- ☐ Other _____ _____

MEDICATIONS

_____

_____

Pharmacy name: _____

Pharmacy Phone #: _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other _____

Signature

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

Signature: _____ Date: _____

(FRONT & BACK)

Financial Consent

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read the following:

PAYMENT: Payment in full is due at time of service unless prior financial arrangements are made. Our practice accepts cash, checks, Visa, MasterCard, Discover and American Express.

We find that some of our patients prefer to divide the cost of treatment up into equal monthly payments using an outside financing arrangement. Ask us about Care Credit.

INSURANCE: Insurance is a contract between the patient and/or employer and the insurance company. It is NOT a contract between our office and your insurance company. Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company for service and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full.

MINOR: Payment for services for the treatment of minors and is the responsibility of the adult accompanying the minor.

MISSED APPOINTMENTS: once an office visit has been made, please remember that this time has been reserved specifically for you. We reserve the right to charge a $55.00 fee for each hour scheduled for all cancelled or missed appointments without 48-hour notice.

COLLECTION FEES: In addition to the outstanding account balance, all fees incurred to collect payment (including collection agency and legal fees) will be billed to and payable by the patient's account holder.

FINANCIAL CONSENT: The Patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY AND AGREEMENT.

X_____

NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by / to anyone outside of our practice. You may gain access to this information if you desire. 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 your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on April 14, 2003 and will remain in effect.

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. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy or 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.

- ## Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

- ## Your Authorization

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member picking up records, referral to dental specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

- ## To Your Family and Friends

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

- ## Persons Involved in Care

We may use or disclose health information to notify, or assist in the notification of (included identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure or your health information, we will provide you with an opportunity to

object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to that person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Relation Services: Our dental office does not use patient information for any marketing purposes. We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when it is required by law to do so (i.e. missing person, etc.)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to lawfully authorize federal officials health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or 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 may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for any purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing. It must explain why the information should be amended. We may deny your request under certain circumstances.

- **Questions and Complaints**:

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right, 2) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) 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: Lance Osborne, DDS, Privacy Officer, Owner

Telephone: 479-442-4051

Address: 245 Van Asche Drive
Fayetteville, Arkansas 72703

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have been offered and / or received a copy of Lance Osborne Dentistry's Notice of Privacy Practices.

I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party. I understand that I may request a copy of the privacy policies at any time.

Expires 3 years from initial signature; insurance change; patient reaches the age of 18

I consent for the office of Dr. Lance Osborne to share my personal information with the following: (family, friends, etc.)

Name / Relationship / Phone Number

_____ / _____ / _____

_____ / _____ / _____

Signature: _____