Bellissimo Dentistry

Patient Registration

Date_____

Patient Name_____Preferred Name_____

Sex: M F Age_____ DOB_____-_____-_____ Marital Status: Single/Married/Divorced/Widow

SS#_____-_____-_____ Phone # H_____ C_____ W_____

Address_____City_____State_____Zip_____

Email_____ Preferred Contact Method: Text/ Call/ Email

Occupation_____ Employer_____

Student Y/N School/College_____ City_____ State_____ FT/PT

How did you hear about us: _____

Emergency Contact Name_____ Phone Number_____

If the person responsible for this patient account is different than this patient, or if the patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to "Insurance information section."

Name of Responsible Party_____Relationship to Patient_____

Sex: M F Age_____ DOB____-_____-_____ Marital Status: Single/ Married/ Divorced/ Widow

SS#_____-____-_____ Phone# C_____ H_____ W_____

Address_____ City_____ State_____Zip Code_____

Email_____Preferred Contact Method: Text/ Call/ Email

Occupation_____ Employer_____

Primary Insurance Information

Policy Holders Name_____Relationship to Patient_____

Policy Holders DOB_____-_____-_____ Name of Employer_____

Insurance Company_____ Insurance Phone #_____

Member/Subscriber ID#_____ Group #_____

Secondary Insurance Information

Policy Holders Name_____ Relationship to Patient_____

Policy Holders DOB_____-_____-_____ Name of Employer_____

Insurance Company_____ Insurance Phone #_____

Member/Subscriber ID#_____ Group #_____

ALL HEALTH-RELATED QUESTIONS ARE CONFIDENTIAL AND FOR OUR RECORDS ONLY

1. Date of last dental examination_____ Previous Dental Provider_____
2. Date of last physical examination_____ Physician's Name_____
3. Have you been hospitalized in the last 2 years for any reason? Please Explain
   _____
4. What is the reason for your dental visit? _____
5. Do you feel nervous about dental treatment? _____
6. Do you have any special request of needs regarding dental treatment? Please Explain:
   _____
7. Is there anything about your smile you would like to change? Please Explain
   _____

Please clearly list all medications, vitamins, herbal supplements and/or cures

_____
_____

Please circle allergies and list any reactions

Aspirin_____ Penicillin_____ Sulfa_____ Codeine _____

Latex_____ Local Anesthetics_____ Iodine _____ Metals_____

Hay Fever_____ Other _____

Please circle and explain any of the following that apply

Artificial joints	Drug Addiction _____	Jaundice
Asthma	Emphysema	Kidney Dysfunction
Anemia	Epilepsy or Seizures	Liver Disease
Angina Pectoris	Eating Disorder	Mitral Valve Prolapse
Any Transplants/ Implants	Fainting or Dizzy Spells	Mental Disorder
Arthritis	Glaucoma	Psychiatric Treatment
Auto-Immune Disorder _____	Heart Attack _____	Rheumatic Fever
Bleeding Problems	Heart Disease	Sickie Cell Disease
Blood Transfusion	Heart Surgery _____	Stroke _____
Blood Pressure (high or low)	Heart Murmur	Steroid Therapy
Congenital Heart Conditions	Heart Pacemaker	Thyroid Disease
Cancer _____	Hemophilia	TMJ Disorder
Chemotherapy/ Radiation	Herpes	Tobacco Products
Cold Sores	Hepatitis (A-Infectious B-Serum C-Other)	Tuberculosis
Diabetes (Type I or Type II)	HIV (Positive, ARC, AIDS)	Treatment Pre-Med

Women: Taking Oral Contraceptives? (Y/N) Pregnant (Y/N) Breast Feeding? (Y/N)

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name_____ Signature _____ Date_____

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMNET

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patients and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collection received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by any insurance company.

A monthly service charge at a fixed rate of 18%per month of the unpaid balance as of the day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimates listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or license employee at the time the services are rendered, or with five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court cost where such legal services are necessary. I authorize the release of financially indefinable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as describe become necessary.

I grant my permission to you or your assignee to telephone me at home or at my work place to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangement or quality of care are null and void.

We understand there are times when emergencies and/or unexpected obligations occur and you may need to cancel your appointment. However, when you do not show up and/or fail to call and cancel at least 24 hours prior, you are preventing other patients from scheduling much needed treatment.

I understand that if I need to cancel or reschedule, it must be done 24 hours prior to my scheduled appointment. **A Fifty Dollar Fee ($50) will be charged to your account for no show or same day cancellations. This fee will not be covered by your insurance company.**

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

_____ _____

Signature of Patient, Parent or Guardian Date

Relationship to Patient _____

Consent To Proceed

I authorize Dr. Alexander Matheson DMD and/or such associates or assistants as s/he may designate to preform those procedures as may be deemed necessary or advisable to maintain my dental health or the dent health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxygen). Analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand the administration of local anesthetic may cause and untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetics may contact the eyes and facial tissue and cause reactions.

I understand that as part of the dental treatment, including preventive procedures such as cleaning and basic dentistry, including fillings of all types, teeth may remain sensitive or even possible quite painful both during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissue to be inadvertently abraded or lacerated (cut) during routine dental procedure. In some cases, sutures or additional treatment may be required.
I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drills components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a service of X-rays to be taken by a physician or hospital any may, in rate cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescriptions drugs that are currently being taken or that have been taken in the past, such a Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complication of non-healing of the jaw bones following oral surgery or tooth extractions.

I do, voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____ Date: _____

Signature: _____
(Patient, Legal guardian or authorized agent of patient.)

Witness: _____ Date: _____

Patient Photography Release & Consent Form

I, _____, hereby authorize the doctors, staff, and representative of Bellissimo Dentistry to take photographs (hereafter referred to as “images”) of my face, jaw, mouth, and teeth.

I approve of these images being used as a record of my or child(s) care. I understand that these images may be cropped or altered. I understand that these images may be used for clinical, treatment and insurance purposes.

I understand that I may revoke or withdrawn this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

_____

Patient Name (print)

_____

Signature

_____

Date

NOTICE OF PRIVACY PRACTICE

(DENTAL)

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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.

We may use and disclose your medical records only for each of the following purpose: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related service by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operation include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your 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 actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protection health information.
- The right to receive an accounting of disclosure of protected health information.
- 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 practice with respect to protect health information.

This notice is effective as of _____, 2021 and we are required to abide by the terms of the Notice of Privacy currently in effect. We reserve the right to change the term of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information:

For more information about HIPPA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775