

PATIENT INFORMATION

Welcome to our practice! So that we may provide you with the best possible care, please complete both sides of this questionnaire. All information is completely confidential.

PATIENT NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SEX _____ MARITAL STATUS _____ SPOUSE'S NAME _____

PATIENT DATE OF BIRTH _____ PATIENT SS# _____

EMPLOYER _____ HOW LONG? _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

ARE YOU A STUDENT? _____ SCHOOL _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IF YOU ARE A MINOR, PERSON RESPONSIBLE FOR YOUR ACCOUNT _____

RELATIONSHIP TO PATIENT _____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT? _____

RELATIONSHIP TO PATIENT _____ PHONE # _____

DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME _____ SS# _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SUBSCRIBER # _____ GRP # _____

INSURANCE COMPANY _____

CLAIM FILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE PHONE # _____

OVER ----->

MEDICAL HISTORY

Have you been under the care of a physician during the past two years? _____

If yes, for what? _____

Physicians Name _____ Phone _____

What medications are you currently taking? _____

Are you allergic to any medications, if yes please list _____

Are you allergic to any other substance, if yes please list _____

Have you been hospitalized in the past five years? _____

Please check if you have a history of the following:

- | | | | |
|-----------------------------|-------------------------|---------------------------|------------------|
| _____ HEART ATTACK | _____ HEART SURGERY | _____ HEART DISEASE | _____ CHEST PAIN |
| _____ RHEUMATIC FEVER | _____ HEART MURMER | _____ HIGH BLOOD PRESSURE | _____ PACEMAKER |
| _____ ARTIFICIAL VALVE | _____ ARTIFICIAL JOINT | _____ ARTHRITIS | _____ STROKE |
| _____ TUBERCULOSIS | _____ GLAUCOMA | _____ ULCER | _____ PREGNANT |
| _____ EMPHYSEMA | _____ DIABETES | _____ THYROID PROBLEMS | _____ ASTHMA |
| _____ RADIATION/CHEMO | _____ CANCEROUS TUMORS | _____ HEPATITIS | _____ AIDS/HIV |
| _____ EPILEPSY | _____ SEIZURES | _____ FAINTING/DIZZINESS | _____ HAY FEVER |
| _____ MITRAL VALVE PROLAPSE | _____ BLOOD DISORDER | _____ SHORTNESS OF BREATH | |
| _____ VENEREAL DISEASE | _____ LATEX SENSITIVITY | _____ CONTACT LENSES | |

DENTAL HISTORY

What is the reason for your visit today? _____

Date of last dental visit _____ Previous Dentist _____

Do you have a history of the following:

- | | | | |
|--|-----------------------|--------------------------|-------------------|
| _____ TOOTH SENSITIVITY | _____ GUMS BLEED/HURT | _____ FOOD IMPACTION | _____ MOUTH ODORS |
| _____ UNPLEASANT TASTE | _____ PAIN AROUND EAR | _____ CLENCHING/GRINDING | _____ ORAL HABIT |
| _____ SMOKING | _____ SWELLING/ LUMPS | _____ PERIODONTAL | |
| _____ COMPLICATIONS AFTER DENTAL VISIT | | | |

Patient Signature _____ Date _____

FINANCIAL POLICY

Payment for services rendered are due at the time of service unless financial arrangements are made in advance.

We are a fee for service practice. Although we treat patients with many types of insurance coverage, we are not contracted with any insurance companies. As a convenience to our patients we will file a claim with your insurance company. Insurance coverage is a contract between the patient and his/her insurance carrier. We cannot guarantee if, how, or when your insurance company pays. Patients who carry dental insurance understand that all dental services furnished are charged in full directly to the patient. As a courtesy to our patients with insurance, we estimate what your out of pocket expense will be and collect that payment at the time of service. We do not represent this estimate as a guarantee of benefit or coverage. We then allow your insurance company 60 days to remit payment. Any balance left unpaid after 60 days regardless of if or how the insurance company pays is due in full from the patient. By signing below, you allow us to release information to your insurance company for the purpose of claim filing and you allow your insurance company to release assignment of benefits to us.

For our patients with DELTA DENTAL INSURANCE, Delta Dental does not accept assignment of benefits. In other words, they will not remit payment to us directly. The above policy applies except, we all Delta 30 days to pay YOU. After 30 days the balance on your account, regardless of if or how Delta pays you, becomes due in full from you.

Any fee estimate given for dental care can only be extended for a period of six months from the date of the estimate.

We do require that our patients provide us with at least 24 hours notice to cancel an appointment in order to avoid a cancellation fee.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

** By signing this form, you acknowledge and understand that all payments are due at the time *services are rendered*. Also be advised that we do use a collection company for any defaulted balances. Accounts that are sent to collections will then be responsible for the defaulted balance, plus a 40-50% collection fee. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Payment Options:

1. Cash---includes money orders and personal checks.
2. Visa/Mastercard---includes debit cards with the Visa/Mastercard logo.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party

Elizabeth Riggs, DDS

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 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 04/19/03 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. 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 of 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 providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us 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 (including 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 of your health information, we will provide you with an opportunity to object to such uses or 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 the 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-Related Services: 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 we are required to do so by law.

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 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 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 will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 purposes, 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 location, 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, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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: Anita Pruski_____

Telephone: (504) 891-1115_____ Fax: (504) 891-8077_____

E-mail: eriggsdds@yahoo.com_____

Address: 3442 Magazine Street, New Orleans, Louisiana 70115_____

Elizabeth Riggs Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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