DENTAL CARE ASSOCIATES
720 N. Sycamore Avenue
Sioux Falls, SD 57110
605.338.6118

PATIENT INFORMATION

Last name: First: Middle:			What do you like to be called?
Birth date: / /	Age:	Sex: ❑ M ❑ F	❑ Single ❑ Married ❑ Minor
Street address:		Phone (H):	Phone (C):
City:	State:	Zip:	E-Mail:
Social Security #:		Occupation:	
Employer:		Phone (W):	Phone (other):
Other family members seen here:			
Whom may we thank for referring you to our office?			

INSURANCE INFORMATION

Name of person responsible for bill:	Check one: ❑ Patient ❑ Parent ❑ Spouse ❑ Other
Address (if different from patient):	
Dental Insurance Co.:	Group #:
Method of Payment: ❑ Insurance and co-payment ❑ Payment in full at visit	

FAMILY INFORMATION

Husband (or father if minor)		**Wife (or mother if minor)**	
Name:		Name:	
Address:		Address:	
Phone (H):	Phone (W):	Phone (H):	Phone (W):
Birth date: / /	SS#:	Birth date: / /	SS#:
Employer:		Employer:	
Dental Insurance Co:	Group #:	Dental Insurance Co:	Group #:

EMERGENCY CONTACT

Name of friend or relative (not living at same address):	Relationship	Home phone:	Work phone:

AUTHORIZATION / SIGNATURE OF RESPONSIBLE PARTY

IMPORTANT: We require a **24-hour notice** when canceling appointments. Failure to do so may result in a broken appointment fee. Your cooperation is greatly appreciated.

I hereby authorize Dental Care Associates to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I understand that I am responsible for all costs of dental treatment. I authorize my insurance benefits be paid directly to the dentist. I also authorize Dental Care Associates or the insurance company to release any information required to process my claims. The above information and the medical history are true to the best of my knowledge.

X _____ _____

Patient/Guardian signature ❑ *Adult Patient* ❑ *Father* ❑ *Mother* ❑ *Guardian* *Date*

DENTAL CARE ASSOCIATES

720 N. Sycamore Avenue
Sioux Falls, SD 57110
605.338.6118

Health Questionnaire

Patient Name: _____ Birthdate:_____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records and will be considered confidential.

Dental

1. Are you having any discomfort at this time? ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain _____
3. Date of last dental visit _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
5. How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard

Mouth

6. Do you or have you ever had any of the following?

Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold.....	Yes	No
Frequent blisters, lips/mouth	Yes	No	Sensitive to sweets.....	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	If so, when _____	Yes	No
Difficulty opening or closing jaw	Yes	No	Change in bite	Yes	No

7. Do you use the following? ☐ Brush ☐ Dental floss ☐ Fluoride rinse ☐ Other _____
8. Are you satisfied with the appearance of your teeth? ..... Yes No

Medical

1. Name and address of your physician _____
2. Has there been any change in your general health within the past year? ..... Yes No
3. When was your last physical examination? _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. Do you have or have you had any of the following diseases or problems?
   a) Rheumatic fever or rheumatic heart disease..... Yes No
   b) Congenital heart disease..... Yes No
   c) Cardiovascular disease (heart problems, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc..... Yes No
   d) Artificial or replacement valves ..... Yes No
   e) Mitral valve prolapse ..... Yes No
   f) Pacemaker ..... Yes No
   g) Allergy ..... Yes No
   h) Sinus problems..... Yes No
   i) Asthma or hay fever ..... Yes No
   j) Hives or a skin rash ..... Yes No
   k) Fainting spells or seizures ..... Yes No
   l) Diabetes ..... Yes No

(over)

m) Hepatitis, jaundice or liver disease ..... Yes No
n) Arthritis or inflammatory rheumatism ..... Yes No
o) Artificial or replacement joints, prosthetic ..... Yes No
p) Digestive system - ulcers or stomach disorders (colitis) ..... Yes No
q) Kidney problems ..... Yes No
r) Tuberculosis ..... Yes No
s) Immune system disorders (including AIDS, HIV) ..... Yes No
t) Sexually transmitted disease ..... Yes No
u) Other _____

6. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ..... Yes No
7. Have you ever tested positive for the AIDS virus? ..... Yes No
8. Do you have any blood disorder such as anemia? ..... Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
10. Are you taking any of the following?
    a) Antibiotics or sulfa drugs ..... Yes No
    b) Anticoagulants (blood thinners) ..... Yes No
    c) Medicine for high blood pressure ..... Yes No
    d) Cortisone (steroids) ..... Yes No
    e) Tranquilizers ..... Yes No
    f) Antihistamines ..... Yes No
    g) Aspirin ..... Yes No
    h) Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
    i) Digitalis or drugs for heart problems ..... Yes No
    j) Nitroglycerin ..... Yes No
    k) Other medications _____
    l) If "yes" to any of above, state drug name, dosage and frequency _____
11. Are you allergic or have reacted adversely to:
    a) Local anesthetics ..... Yes No
    b) Penicillin or other antibiotics ..... Yes No
    c) Aspirin ..... Yes No
    d) Codeine or other narcotics ..... Yes No
    e) Other _____
12. Do you smoke or use tobacco products? ..... Yes No
13. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
14. Are you pregnant? ..... Yes No
15. Have you ever taken a bisphosphonate drug, antiresorptive drug or antiangiogenic drug? ..... Yes No

Preferred Pharmacy/Address _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient or Parent Date Signature of Dentist Date

Date	Medical Update	Initial

720 N. Sycamore Avenue
Sioux Falls, SD 57110
605.338.6118

Important Information about your Dental Insurance

Dental benefit plans can vary from company to company with different procedures covered or not covered. In other words, your insurance plan will pay only what it allows for each service, regardless of the actual fee. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions.

As a courtesy to our patients, we will file your insurance claim and do our best to inform you of your financial portion. We only ask that you pay your ***estimated portion at the time of treatment.*** Our goal is to help you obtain your maximum benefits by prompt and efficient processing of your claim. Thank you for choosing Dental Care Associates.

Our Responsibilities:

1. Complete your insurance claim forms and submit them to your carrier.
2. Use current American Dental Association coding for efficient reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time.

Your Responsibilities:

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with ***current*** information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you, your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance upon billing.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical records and other information about my dental treatment to third party payers.

_____ _____

Signature of Patient or Guardian Date

DENTAL CARE ASSOCIATES

720 N. Sycamore Avenue
Sioux Falls, SD 57110
605.338.6118

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 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 01/01/2003, and will remain in effect until it needs replacing to remain current with the laws.

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 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 significant changes are made to our privacy practices, changes of this Notice will be made and the new Notice will be 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 healthcare 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 make 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, 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 another 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 your health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and 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 officials having lawful custody of protected 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, post cards, letters, emails, or text messages).

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 a fee of $25.00 per patient. This includes material, x-ray duplicates, staff time and if mailed, postage. 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 if you have questions.)

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. 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.

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 a 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 submit a complaint 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.

Contact Officer:

Telephone: (605) 338-6118

Address:
Dental Care Associates
720 N Sycamore Ave
Sioux Falls, SD 57110

DENTAL CARE ASSOCIATES

720 N. Sycamore Avenue
Sioux Falls, SD 57110
605.338.6118