TIME 01:24 PM DATE 12/19/201

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency First Name

Emergency Last Name:

Emergency Phone#

Former Dentist

Referral Source

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 1:25 PM | Lindsey Dentistry PLLC | Date 12/19/2013

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed	Yes No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Lindsey Dentistry PLLC

Acknowledgement of Receipt of Notice of Privacy Practices

Lindsey Dentistry PLLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgment.

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to contact our Privacy Officer:
Mail: Lindsey Dentistry PLLC
Attention Privacy Officer
261 Main St. - PO Box H Claysville, PA 15323

Email: Practice@LindseyDentistry.com Phone: (724) 663-7735

Acknowledgement of Receipt of Privacy Practices

I _____ acknowledge that I have received our Notice of Privacy Practices for

A. **MYSELF ( )** or B. _____ on _____.
Name of PATIENT I am representing Date

X_____ _____
Signature of Patient or Guardian Relationship/Authority
(IF a personal representative signs on behalf of the individual)

Acknowledgement of Receipt of Financial Policies

I _____ acknowledge that I agree to the financial policies set forth on the reverse of this page. A copy of the policies may be requested from our office or can be found online at www.LindseyDentistry.com.

X_____ _____
Signature of Patient or Guardian Date

****FOR STAFF****

Good Faith Efforts to Obtain Acknowledgement of Receipt

I provided the above named patient/representative with the Notice of Privacy Practices & Financial Policy.

Describe how notices were provided:
- ☐ Offered copy and individual accepted delivery
- ☐ Offered copy and Individual refused to accept delivery
- ☐ Other: _____

Describe Efforts to obtain signature on acknowledgment of notice & policies form:
- ☐ Patient/Representative refused to sign _____
- ☐ Other: _____

Signature of **STAFF MEMBER**: _____ Date: _____

Lindsey Dentistry PLLC

Financial Policies

We are dedicated to providing you the best possible care, and we want you to completely understand our financial policies. We provide dental services in good faith with the expectation that we will receive payment for those services. YOU THE PATIENT OR GUARDIAN IS ULTIMATETY RESPONSIBLE FOR ALL CHARGES.

Insurance - Your insurance policy is a contract between you and your insurance company, not the doctor or the dental office. Lindsey Dentistry PLLC is an assignment office, which means that if you provide the necessary information, we will file your primary and secondary insurance claims as a courtesy on behalf of you and request your insurance company to pay the dental office directly. If your insurance company denies payment to the dental office directly, the patient will be notified and the patient will be responsible for payment to the dental office and collecting the money from their insurance company. We will promptly handle any requests for information to facilitate claims and payment. Patients are required to pay the remaining balance (limited to any applicable negotiated fees provided by your contract) if the insurance company does not pay your claim in full.

Co-pays - Co-pays and deductibles are due on the day services are rendered. NOT ALL INSURANCE PLANS cover all services rendered by our office. It is your duty to know your benefits and coverage before treatment. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. It is your responsibility to notify our office of any changes in home address, contact numbers, or insurance coverage. You can request your coverage by calling your insurance company. With your permission, you may have the insurance company fax your coverage schedules to our office at 724-663-7735. With system and insurance company limitations in mind, we may be able to electronically request your coverage via our live eligibility request feature at our office.

Self-Pay/Cash Pay - Payment is required at the time of service. For the convenience of our patients desiring extended credit, we accept Visa, MasterCard, Discover Card, and CareCredit. If the patient/responsible party is unable to pay at the time of service, they CAN be asked to reschedule their appointment to a time when payment can be made, or to make payment arrangements with a "MANAGING MEMBER" of the dental practice.

STATEMENT BALANCES - PAYMENT IN FULL for any unpaid Insurance or Cash Pay balances will be due within THIRTY (30) DAYS upon receipt of a statement from our office. Although it is not our routine practice or desire, we HOLD THE RIGHT to apply reasonable finance charges and/or late payment penalties to your account for aged balances past thirty (30) days. We also hold the right to turn your account over to collections after non-payment IN FULL of services past NINETY (90) days. It is your duty to contact our office for potential arrangements if your account is between SIXTY (60) and NINTY (90) DAYs past due to avoid possible turn-over to collections.

Divorce or Separation - In the case of divorce or separation, the person who brings the child in for treatment is responsible for payment at time of service. The account will be in the name of the person who has custody.

Returned Checks – We hold the right to charge your account up to a THIRTY DOLLAR ($30.00) service fee for checks returned by the bank for any reason. Returned Checks, including the service fee, must be paid by cash, credit card or money order within 10 working days from the date we notify you of a returned check.

AGREEMENT TO PAY AND INSURANCE AUTHORIZATION:

I the patient of care request and authorize Lindsey Dentistry PLLC and staff, to provide me with dental services. I understand that I am personally responsible for the charges for the services that I receive. I agree to pay all reasonable fees and collection costs incurred by Lindsey Dentistry PLLC, if my account is not paid as agreed. I hereby authorize Lindsey Dentistry PLLC and staff, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to Lindsey Dentistry PLLC and its rendering Providers of my care.

Lindsey Dentistry PLLC

NOTICE OF PRIVACY PRACTICES

Effective Date: 09/23/2013 .

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 PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Title: Privacy Officer Telephone: (724) 663 – 7735 Fax: (724) 663 – 7735

Email: Practice@LindseyDentistry.com Address: 261 Main St. – PO Box H Claysville, PA 15323

OUR LEGAL DUTY

We are required by law to protect the privacy of your protected health information ("medical information"). We are also required to send you this notice about our privacy practices, our legal duties, and your rights concerning your medical information.

We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on the date set forth at the top of this page, and will remain in effect unless 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 any change in our privacy practices and the new terms of our notice applicable to all medical information we maintain, including medical information we created or received before we made the change.

We may amend the terms of this notice at any time. If we make a material change to our policy practices, we will provide to you the revised notice. Any revised notice will be effective for all health information that we maintain. The effective date of a revised notice will be noted. A copy of the current notice in effect will be available in our facility and on our website if applicable. You may request a copy of the current notice at any time.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patients' medical information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

USES AND DISCLOSURES OF YOUR MEDICAL INFORMATION

Treatment: We may disclose your medical information, without your prior approval, to another dentist, a physician or other health care provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Health Care Operations: We may use and disclose your medical information, without your prior approval, for health care operations. Health care operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your medical information or to disclose it to anyone for any purpose. Once you give us authorization to release your medical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice. We will obtain your authorization prior to using your medical information for marketing, fundraising purposes or for commercial use.

Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your medical information to communicate with you about health-related products, benefits, services, payment for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an

employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker's compensation laws.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Business Associates: We may disclose your medical information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact our Privacy Officer for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to our Privacy Officer. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. You should submit your request in writing to our Privacy Officer.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we deny your request, you may have a statement of your disagreement added to your medical information. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. Except in limited circumstances, we are not required to agree to your request. But if we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to our Privacy Officer. Except as otherwise required by law, we must agree to a restriction request if:

1. except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment); and
2. the medical information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full by the patient.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by means or to locations that you specify. You should submit your request in writing to our Privacy Officer.

Breach Notification: You have the right to receive notice of a breach of your unsecured medical information. Breach may be delayed or not provided if so required by a law enforcement official. You may request that notice be provided by electronic mail. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if we know the identity and address of such individual(s).

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. Please contact our Privacy Officer to obtain this notice in written form.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your medical information, or about how we communicate with you about your medical information (including a breach notice communication), you may contact to our Privacy Officer.

You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office for Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical 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.

REQUEST FOR DENTAL RECORDS RELEASE AUTHORIZATION

Lindsey DENTISTRY
261 MAIN ST. CLAYSVILLE, PA

I, _____ ,

authorize _____
(Previous/Current Dental Office)

_____
(Address)

_____
(City, State, Zip Code)

_____
(Phone #)

_____
(Fax #)

to release copies of my dental records with respect to any dental care and treatment to:

Lindsey Dentistry PLLC

PO Box H - 261 Main St. Claysville, PA 15323

Phone/FAX: (724) 663-7735 EMAIL: Practice@LindseyDentistry.com

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and/or x-rays, which pertain to me and my past, current, and ongoing oral health.

I hereby release Lindsey A. George, DDS & Lindsey Dentistry PLLC from all legal responsibility or legal liability that may arise from the release of such information. I understand that I may revoke this consent at any time, except that the action has been taken in reliance upon it, and that in any event this consent shall expire ninety (90) days after the date below.

A reproduced copy of this authorization shall be as valid as the original.

Patient Printed Name_____ DOB_____

Patient Signature_____
(Patient/Legal Guardian)

Relationship to Patient:_____

Patient Address: _____ Date: _____