NEW PATIENT REGISTRATION

Patient Information

First Name_____ Last Name_____

Preferred Name_____ Date of Birth_____ Sex: ☐ Male ☐ Female

Address_____ City_____ State_____ Zip_____

Soc. Sec #._____ Driver's License #_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____ Emergency Contact _____ Phone_____

How would you like to receive appointment reminders and correspondence? ☐ Email ☐ Text Message ☐ Personal Phone Call

Is the patient responsible for payments? ☐ Yes ☐ No

Responsible Party (if other than patient)_____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other

Responsible Party ****Please fill out this section if patient is NOT responsible party****

First Name_____ Last Name_____

Address_____ City_____ State_____ Zip_____

Employer_____ City_____ State_____ Zip_____

Soc. Sec #._____ Driver's License #_____ Date of Birth_____

Home Phone_____ Work Phone_____ Cell Phone._____

Primary Insurance	**Secondary Insurance**
Policyholder Name_____	Policyholder Name_____
SSN or Member ID#_____	SSN or Member ID#_____
Policyholder Address (if different from patient's)	Policyholder Address (if different from patient's)
_____	_____
Ins. Company_____	Ins. Company_____
Group #_____	Group #_____
Employer_____	Employer_____

Shorey Dentistry
Comprehensive Family Care

Patient Name_____ Birthdate_____

Cell # ( ) _____ Home # ( ) _____ Work # ( ) _____

Are you currently under a physician's care? ☐ Yes ☐ No If yes, please explain _____

Have you ever had a serious illness or surgery? ☐ Yes ☐ No If yes, please explain _____

Have you ever taken Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken meds for Osteoporosis? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Please list any medications, pills or drugs you are taking: _____

WOMEN ONLY: Are you taking birth control? ☐Yes ☐No Are You Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No

Do You Have Allergies To Any Of The Following?

YES NO		YES NO		YES NO		YES NO	
☐☐	Aspirin	☐☐	Erythromycin	☐☐	Metals	☐☐	Other
☐☐	Codeine	☐☐	Jewelry	☐☐	Penicillin		_____
☐☐	Dental Anesthetic	☐☐	Latex	☐☐	Tetracycline		_____

Check Any Of The Following That Apply To Patient Health History:

Y N		Y N		Y N	
☐☐	Abnormal Bleeding	☐☐	Fainting Spells	☐☐	Pain in Jaw Joints
☐☐	Alcohol Abuse	☐☐	Fever Blisters	☐☐	Psychiatric Problems
☐☐	Alzheimer's	☐☐	Freq. Headaches	☐☐	Radiation Therapy
☐☐	Anemia	☐☐	Glaucoma	☐☐	Rheumatic Fever
☐☐	Angina Pectoris	☐☐	HIV+/AIDS	☐☐	Seizures
☐☐	Arthritis	☐☐	Heart Disease	☐☐	Shingles
☐☐	Artificial Heart Valve	☐☐	Heart Surgery	☐☐	Sickle Cell
☐☐	Asthma	☐☐	Hemophilia	☐☐	Sinus Problems
☐☐	Blood Transfusion	☐☐	Hepatitis A	☐☐	Stroke / TIA
☐☐	Cancer/Chemo	☐☐	Hepatitis B/C	☐☐	Thyroid Disease
☐☐	Colitis	☐☐	High Blood Pressure	☐☐	Tuberculosis
☐☐	Congenital Heart Disorder	☐☐	Joint Replacement	☐☐	Ulcers
☐☐	Diabetes	☐☐	Kidney Disease	☐☐	Venereal Disease
☐☐	Difficulty Breathing	☐☐	Liver Disease	☐☐	Yellow Jaundice
☐☐	Drug Abuse	☐☐	Low Blood Pressure	☐☐	Other_____
☐☐	Emphysema	☐☐	Mitral Valve Prolapse	☐☐	Other_____
☐☐	Epilepsy	☐☐	Pacemaker		

Do you have any disease, condition or problem not listed above? ☐Yes ☐No If yes, please explain _____

_____

_____

I understand the above information is necessary to provide the safest and most efficient dental care for me. I certify I have read and answered the above questions to the best of my knowledge. I will not hold my dentist or any member of the dental team/staff responsible for any errors or omissions that I have made in the completion of this form. I hereby agree to notify the dentist if any changes occur to my reported health status.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Patient/Guardian Signature_____**Date**_____

18181 Butterfield Blvd. #160, Morgan Hill, CA 95037 (408) 778-3384

SCHEDULING AND FINANCIAL POLICY

The staff at Shorey Dentistry is committed to providing the best dental care possible. Your clear understanding of our Financial Policy is important to our professional relationship. If you have dental insurance to help with the cost of your care we want to help you obtain the maximum use of these benefits. Your insurance policy is a legal contract between you and your dental insurance company. Our role is to assist you with filing your claims. While we do our best to work within your insurance limit and/or inform you of services not covered by your insurance plan; our main concern is to recommend treatment based upon your individual needs and the best course of treatment for you. Many services needed for your dental health may not be covered. Please do not let your insurance policy limit your dental health. Please ask if you have questions about fees, the financial policy or your responsibility.

INSURANCE POLICIES

If you have private care insurance plans (PPO), we will accept assignment of your insurance benefits. However, your co-payment (share of cost), deductible and any charges not covered by your insurance are your responsibility. Although we maintain computerized records of insurance coverage, these details are subject to change. Therefore, it is impossible to give you an absolutely guaranteed quote at the time of service. To facilitate the financial process, it is your responsibility to provide us with your current insurance information and to inform us of any changes. We provide a thorough estimate of your portion based on the most up-to-date information provided by your insurance carrier, but it is **only an estimate**.

Pre-authorizations can help determine the amount of your co-pay ahead of time but we cannot guarantee the insurance payment as estimated. The approximate insurance payment and copay collected at the time of service is to be a guideline until the final insurance payment is received and the account has been reconciled. All treatment plans and charges will be discussed together so each patient is completely comfortable with the financial aspect of their dental care.

PATIENT RESPONSIBILITY

We submit claims directly to your insurance as a courtesy. Insurance companies usually pay only a portion of the total fee for most procedures. If insurance does not pay their portion within 90 days, Shorey Dentistry reserves the right to request payment in full for services from you. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Ultimately you are responsible for all charges incurred in our office regardless of any insurance company's policies or arbitrary determination of customary rates. I hereby authorize payment directly to my dentist by my dental benefits carrier.

FINANCIAL OPTIONS

Shorey Dentistry requires payment in full of your estimated out-of-pocket portion at the time of services unless specific financial arrangements in writing are made in advance of your appointment. For your convenience, we accept MasterCard, Visa, American Express and Discover as well as cash and personal checks. If you are in need of an extended finance option, please ask one of the patient services staff members for more information prior to your appointment.

MONTHLY STATEMENT

If you have a balance on your account, you will receive a monthly statement. The balance is due and payable when issued and is past due if not paid after thirty (30) days. In the event that reasonable attempts have been made to collect delinquent monies, accounts may be referred to a collection agency or attorney and patient agrees to pay all fees incurred. I authorize Shorey Dentistry to contact me by phone, mail, email or text if my account becomes past due in an attempt to resolve the matter.

APPOINTMENT POLICY

We value your precious time and, accordingly, do not double-book our patients to account for no-shows. Your appointment room will be set up with instruments specific to your care as well as having the appropriate personnel reserved *only for you*. This means that you will have little or no time spent in the waiting room and you will have our undivided attention during your visit. When a patient cancels or reschedules at the last minute, it can be very difficult for us to fill the opening. This is unfair to other patients who could have used the time that you reserved. Any cancellation made within **48 HOURS** of your scheduled appointment time will result in a cancellation fee of $40.

We welcome you to our dental family and look forward to helping you achieve the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits more pleasant, please don't hesitate to ask.

18181 Butterfield Blvd., Suite 160 Morgan Hill, CA 95037 (408) 778-3384 ShoreyDDS@gmail.com

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.

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 April 14, 2003 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 your treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist 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 health professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certifications, licensing or credentialing activities.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization:

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health 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 to 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 the 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 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.

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 authorize 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

Right to Inspect & Copy: You have the right to inspect and copy dental information that may be used to make decisions about your care. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. You may request that we provide copies in a format other than paper 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. You may also request access by sending us a letter to the address at the end of this notice.

Disclosure Accounting: You have the right to receive a list of instances in which we were 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. 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.

Restricting: 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 of 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 website or by electronic mail, you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practice or have questions or concerns, please contact us as follows:

Shorey Dentistry
18181 Butterfield Blvd. Suite 160
Morgan Hill, CA 95037
(408) 778-3384
ShoreyDDS@gmail.com

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

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

Per HIPAA Rules you may refuse to sign this HIPAA portion of the acknowledgment form

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

Scheduling and Financial Policies

I have read, understood and accept the terms of the outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Shorey Dentistry. I am fully aware that I am the final responsible party for these commitments. I am also aware that any cancellations or reschedules made within 48 hours of the appointment time will result in a $40 cancellation charge.

_____ _____
(Signature) (Date)

Acknowledgment & Authority

I, _____, Consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance or operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor or other qualified designate. I am also fully aware of the possibility of infections, swelling and paresthesia occurring when any surgical procedures such as extractions of teeth, apical surgery, etc. are involved.

_____ _____
(Signature) (Date)

****For Office Use Only****

We attempted to obtain written Acknowledgment of Receipt of Notice of Privacy Practices, but acknowledgment could not be acquired because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining acknowledgment
___ Other (please specify)