

# WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain good dental health.

Please fill out these forms completely. The better we communicate, the better we can care for you.

## 1 ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST MI MR MRS MS DR

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S. #: \_\_\_\_\_

Home Address: \_\_\_\_\_  
CITY STATE ZIP APT/CONDO #

Single  Married  Divorced  Widowed  Separated

Home #: \_\_\_\_\_ Mobile #: \_\_\_\_\_

WK #: \_\_\_\_\_ Ext. \_\_\_\_\_ DL #: \_\_\_\_\_

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

Where & when are best times to reach you? \_\_\_\_\_

Who may we **Thank** for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

Previous/Present Dentist: \_\_\_\_\_

(Please Circle)  
 Last Visit Date: \_\_\_\_\_

## 2 SPOUSE INFORMATION

Their Name: \_\_\_\_\_

Employer: \_\_\_\_\_

WK #: \_\_\_\_\_ Ext. \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS #: \_\_\_\_\_

**In the event of an emergency, is there someone who lives near you that we should contact?**

Their Name: \_\_\_\_\_ Relation: \_\_\_\_\_

WK #: \_\_\_\_\_ HM #: \_\_\_\_\_

## 3 INSURANCE

### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's S.S. #: \_\_\_\_\_

### Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Insured's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Insured's S.S. #: \_\_\_\_\_

**Person Responsible for Account:** \_\_\_\_\_

WK #: \_\_\_\_\_ Ext. \_\_\_\_\_ HM #: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
Zip

Relationship: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ DL #: \_\_\_\_\_

I hereby authorize payment of insurance benefits to the doctor, unless I have paid my account in full. I am responsible for any fees not covered by insurance, or for any co-payment, at the time services are rendered.

\_\_\_\_\_

Responsible Party Date

# Welcome to Pound and Pound Family Dentistry, PLLC

## PROTECTED HEALTH INFORMATION

### How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination or eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved In Your Healthcare** - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or a funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

### Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at: