

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.

<p>Section 2</p> <p>Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Medicaid ID: _____ Pref. Dentist: _____ Employer ID: _____ Pref. Pharmacy: _____ Carrier ID: _____ Pref. Hyg: _____</p>	<p>Section 3</p> <p>Emergency Contact _____ Previous Dentist _____ Referred By _____ Emergency Contact # _____</p>
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Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Address: _____ Address 2: _____ City, State, Zip: _____ Rem. Benefits: _____	Ins. Company: _____ Address: _____ Address 2: _____ City, State, Zip: _____ Rem. Deduct: _____
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Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other
 Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Address: _____ Address 2: _____ City, State, Zip: _____ Rem. Benefits: _____	Ins. Company: _____ Address: _____ Address 2: _____ City, State, Zip: _____ Rem. Deduct: _____
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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 that you may be taking, c

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

Do you use controlled substances? Yes No If yes _____

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

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

Have you ever had any serious illness not listed above? 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: _____

Berryville Dental Associates

Gina Kaiser, D.D.S.

Nicole Malony, D.D.S.

322 N. Buckmarsh Street, Suite C, Berryville, VA 22611

Tel: (540) 955-0270 Fax: (540) 955-0272 email: berryvilledental@gmail.com

BROKEN APPOINTMENT/COMMUNICATION POLICY

A broken appointment is considered: a cancelled appointment without 24-hour notice or an appointment where the patient does not show as scheduled.

We ask for at least 24 hours advance notice for canceling or rescheduling an appointment; otherwise, a \$50 broken appointment fee may be assessed to your account. We understand that there may be some extenuating circumstance for which you have no control. We will take that into consideration. We will allow two unexcused broken appointments per patient before patient dismissal from the patient. This is done on a case-by-case basis.

I authorize contact from this office to confirm my appointments, treatments & billing information VIA:

___ Cell Phone

___ Home Phone

___ Email (address _____)

Please sign below signifying your understanding of this policy.

Print patient name: _____ Signature: _____

Parent or Guardian Signature: _____ Date: _____

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Financial Responsibility Agreement and Consent to Services

Thank you for choosing our team of dental professionals to serve your dental needs. We are committed to providing you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.

Insurance:

Dental insurance is designed to help offset the cost of dental care. Insurance estimates provide a table of allowances that will assist you in determining your approximate out-of-pocket expenses.

1. Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, whatever the reason.
2. On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimates and pre-estimates are not a guarantee from your insurance company.
3. Your insurance policy is a contract between your employer and your employer's insurance company, we are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. We generally will accept assignment of benefits (payment) from your insurance company but we reserve the right to refuse assignment on certain plans. In that case, full payment is due by you at the time of service and your insurance company will reimburse you directly.
5. If you wish to have us invoice your insurance company directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to Kaiser and Malony, DDS, PC.

Payment Policies: As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our parties for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. Account payment options available include: Cash, Check Visa, Master Card, or Care Credit.

By signing below you are agreeing to all of the terms contained in this Financial Responsibility Agreement and Consent for Services including the following:

1. If you have dental insurance, your estimated portion of payment is due in full at your time of service.
2. If you do not have dental insurance, payment for services is due in full at your time of service.
3. There is a \$35.00 service charge on all returned checks.
4. We reserve the right to charge a missed appointment fee for no-shows or cancellations with less than 24 hours notice.
5. I understand and agree that any account balance not paid within 90 days will be subject to collection activity. In understand Kaiser and Malony, DDS, PC will retain the services of an attorney or collection agency to assist with the collection of any outstanding balance.
6. I understand and agree that I owe an attorney's and/or collection agency's fee of an additional 40% of the amount I owe to Kaiser and Malony, DDS, PC plus 1 ½% per month (18% per annum) on the unpaid balance owed, plus court costs on any account not paid within 90 days of last date of service.
7. I understand and agree that, ultimately, I am responsible for payment on my account. As guarantor, I am responsible for any outstanding balances for other family members listed on the same account, due to Kaiser and Malony, DDS, PC. I understand that all subsequent appointments for the guarantor and/or family members on the same account will not be scheduled until all outstanding balances are paid in full. I understand that any account submitted for collections will be dismissed from the practice.

Print patient name: _____ Signature: _____

Parent or Guardian Signature: _____ Date: _____

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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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must do to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for your written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose.
- for public health purposes, such as contagious disease reporting, investigation, or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- disclosures to governmental authorities and victims of suspected abuse, neglect, or domestic violence.

- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial or to organizations that handle organ or tissue donations.
- uses or disclosures for health-related research.
- uses and disclosures to prevent a serious threat to health or safety.
- uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- disclosures of de-identified information.
- disclosures relating to worker's compensation programs.
- disclosures of a "limited data set" for research, public health, or health care operations.
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the correct information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send in written complaint to the office contact person at the address, fax or email show at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF HIPPA

I acknowledge that I received a copy of Berryville Dental Associates Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____