



Patient Name:	Preferred Name:
Street Address:	
Mailing Address:	
Home Phone:	Work Phone:
Mobile Phone:	May we contact you at work? Y N
Sex: M F	Marital Status:
Date of Birth:	Social Security Number:
Email:	Employer/Occupation:

Responsible Party (required for patients under 18 or if someone other than the patient):

Name:	
Street Address:	
Mailing Address:	
Home Phone:	Work Phone:
Mobile Phone:	May we contact you at work? Y N
Date of Birth:	Social Security Number:

Dental Benefit Policy Holder:

Dental Benefit Company:	Employer:
Date of Birth:	Social Security Number:

Who may we thank for referring you to our office?

I understand that I am responsible for all costs of dental treatment. I hereby authorize Hahn and Hahn Dentistry Partnership DBA Smile Columbia to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental and medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X

Patient Reponsible Party



MEDICAL HISTORY

	Y	N		Y	N
To the best of your knowledge, are you, or have you ever been afflicted with:			Are your teeth sensitive to:		
heart ailment	<input type="radio"/>	<input type="radio"/>	Hot?	<input type="radio"/>	<input type="radio"/>
if so, please explain: _____			Cold?	<input type="radio"/>	<input type="radio"/>
diabetes	<input type="radio"/>	<input type="radio"/>	Sweets?	<input type="radio"/>	<input type="radio"/>
rheumatic fever	<input type="radio"/>	<input type="radio"/>	Biting Pressure?	<input type="radio"/>	<input type="radio"/>
cancer	<input type="radio"/>	<input type="radio"/>	Does food constantly get stuck between certain teeth?	<input type="radio"/>	<input type="radio"/>
epilepsy	<input type="radio"/>	<input type="radio"/>	Do you get frustrated because something always needs treated or repaired when you visit the dentist?	<input type="radio"/>	<input type="radio"/>
high blood pressure	<input type="radio"/>	<input type="radio"/>	Are you dissatisfied with your teeth in any way?	<input type="radio"/>	<input type="radio"/>
respiratory disease	<input type="radio"/>	<input type="radio"/>	Do any of your fillings show when you smile?	<input type="radio"/>	<input type="radio"/>
hepatitis	<input type="radio"/>	<input type="radio"/>	If any of your mercury amalgam fillings need replacement, would you prefer to have a more natural, tooth colored restoration instead?	<input type="radio"/>	<input type="radio"/>
prolonged bleeding	<input type="radio"/>	<input type="radio"/>	Have you ever had any teeth removed?	<input type="radio"/>	<input type="radio"/>
healing complications	<input type="radio"/>	<input type="radio"/>	How long have these teeth been missing? _____		
HIV / AIDS	<input type="radio"/>	<input type="radio"/>	Do your gums bleed when brushing?	<input type="radio"/>	<input type="radio"/>
Do you smoke?	<input type="radio"/>	<input type="radio"/>	Do you ever avoid any part of the mouth while brushing?	<input type="radio"/>	<input type="radio"/>
What is your blood pressure _____			Have you been instructed regarding proper home care?	<input type="radio"/>	<input type="radio"/>
Do you sleep with a cpap?	<input type="radio"/>	<input type="radio"/>	Do you have an unpleasant taste or odor in your mouth?	<input type="radio"/>	<input type="radio"/>
Do you have general health problems?: if so, please specify _____	<input type="radio"/>	<input type="radio"/>	Do you frequently snack between meals or sweets or chew gum?	<input type="radio"/>	<input type="radio"/>
_____			How often do you brush your teeth? _____		
_____			How often do you use floss? _____		
Are you under a physicians care? reason: _____	<input type="radio"/>	<input type="radio"/>	Do you want to learn to control dental disease and retain your teeth?	<input type="radio"/>	<input type="radio"/>
name of physician: _____			Has the fear of discomfort kept you from regular dental visits?	<input type="radio"/>	<input type="radio"/>
Are you currently taking medications? if so, please list? _____	<input type="radio"/>	<input type="radio"/>	Are you deeply concerned about the finances required to return your mouth to excellent dental health?	<input type="radio"/>	<input type="radio"/>

allergy to any drugs please list: _____	<input type="radio"/>	<input type="radio"/>			

We are committed to providing you with the best possible care. If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits.

Payment for services is due at the time services are rendered unless arrangements have been approved in advance. We will be pleased to assist you in processing your insurance claim for your reimbursement. Any remaining balance 30 (thirty) days after we have filed a claim for you becomes your responsibility and is due and payable. If you have secondary insurance we will be happy to show you how to file these claims to be reimbursed by your secondary insurance company. A service charge of 18% per annum accrues on any portion of a balance remaining over 90 (ninety) days.

Financial responsibility for patients that are minors lies with the parent who accompanies the child to the appointment. We cannot bill a parent that is not present in the office. We will happily provide a statement of services and payment receipt to you upon request.

Our staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however;

1. Your insurance is a contract between you, your employer, and your insurance company.
2. The insurance coverage you will receive depends upon the quality of the plan purchased by the employer. Plans vary greatly and insurance companies do not give us the exact reimbursement amounts. Please contact your insurance company if you need an exact reimbursement amount.
3. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

For your convenience you may pay by cash, check Visa, Mastercard, Discover, or American Express. Financing is available with approved credit. Please ask us for details.

When canceling an appointment a 48 hour notice is required. If such a notice is not given, a \$76 fee (the minimum cost of your appointment) will be charged to your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to assist you.

I have read the above Financial Policy and agree to all payment terms. I further authorize the office to release any information concerning my case to my insurance company.

Patient/ Responsible Party Signature

Date



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (AHIPPA®) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by an alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 14, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures for our office. We will not retaliate against you for the complaint.

Please contact us for information:	For more information about HIPPA Or to file a complaint:
Dr. Paul Hahn, DMD, PA	The U.S. Department of Health and Human Services Office of Civil Rights
Dr. Adam Hahn, DMD, PA	200 Independence Avenue, S.W.
690-A Columbiana Drive Ste. A	Washington, D.C. 20201
Columbia, SC 29212	202-619-0257 or Toll Free: 1-877-696-6775



I understand that under the Health Insurance Portability Act of 1998 (HIPAA), I have certain rights regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above mentioned address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature : _____

Date: _____