PIONEER PERIODONTICS & IMPLANT DENTISTRY, PC

JOHN E. RUTLEDGE, DDS, MS
Diplomate of American Board of Periodontology

HOANG-OANH T. LE, DDS, MS
Diplomate of American Board of Periodontology

AARON D. BRADLEY, DDS, MS
Diplomate of American Board of Periodontology

AMY C. KILLEEN, DDS, MS
Diplomate of American Board of Periodontology

Patient First Name:_____ MI:____ Last Name: _____

Street Address: _____

City, State, Zip Code:_____

Telephone: Home: _____Work: _____

Cell: _____E-mail:_____

Social Security Number: _____

Date of Birth: _____ Sex: _____ Age: _____

Employer: _____

Occupation: _____

Students: School of Attendance: _____

Marital Status: (circle) Single Divorced Widowed Married: Spouse's Name:_____

Other Emergency Contact Name/Telephone: _____

Parent(s) Name (if patient is a minor, under 19): _____

Address:_____

Telephone:_____

General Dentist: _____

Other Referring Dentist: _____

Primary Care Physician: _____ Telephone: _____

Preferred Pharmacy: _____ Telephone: _____

BILLING//RESPONSIBLE PARTY INFORMATION

Name: _____

Address:_____

Telephone: _____

Do you have dental insurance? _____Primary Insurance Carrier:_____

Secondary Insurance Carrier: _____

To the best of my knowledge, all of the preceding answers are true and correct. I understand that I am financially responsible for all dental services provided by Periodontal Offices, PC, regardless of dental insurance coverage, which is a contract between the insurance company and the employee. I also authorize the release of my records or dental information, as may be required.

_____ _____

****Patient/Responsible Party Please Sign**** **Date**

4200 Lucile Drive, Suite 100 | Lincoln, NE 68506 | 402.483.7631 | FAX 402.483.1237
info@pioneerperiodontics.com | www.pioneerperiodontics.com

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Patient Name _____ Date of Birth _____

PREMEDICATIONS
- Y N Organ Transplant
- Y N Artificial Heart Valve
- Y N Artificial Joints

CARDIOVASCULAR SYSTEM
- Y N Angina Pectoris-Chest Pain
- Y N Congenital Heart Defect
- Y N Mitral Valve Prolapse
- Y N Pacemaker
- Y N Rheumatic Heart Disease/Fever
- Y N Stroke/Blood Clots
- Y N Heart Attack/Heart Surgery
- Y N High Blood Pressure
- Y N Low Blood Pressure
- Y N History of Endocarditis

BLOOD – LYMPHATICS
- Y N Anemia
- Y N Blood Disorders
- Y N Abnormal Bleeding
- Y N Blood Transfusion

RESPIRATORY SYSTEM
- Y N Asthma/Emphysema
- Y N COPD
- Y N Tuberculosis
- Y N Sinus Problems
- Y N Seasonal Allergies

NERVOUS SYSTEM
- Y N Seizures
- Y N Epilepsy
- Y N Neuritis/Neuralgia/Numbness
- Y N Depression

BONES and JOINTS
- Y N Osteo/Rheumatoid Arthritis
- Y N Back, Neck, Jaw Injury

ENDOCRINE SYSTEM
- Y N Diabetes
- Y N Thyroid Problems

GENITOURINARY/GASTROINTESTINAL
- Y N Kidney Disease
- Y N Stomach/Intestinal Problems
- Y N Liver Disease
- Y N Jaundice
- Y N Ulcers, Reflux Disease
- Y N Eating Disorders

INFECTIOUS DISEASES
- Y N Hepatitis (A,B,C, or other)
- Y N AIDS, ARC, HIV, ANTI-HIV
- Y N Venereal Disease
- Y N Cold Sores

GENERAL
- Y N Cancer-Chemotherapy
- Y N Radiation Therapy
- Y N History of Bisphosphonate Use
- Y N Deafness
- Y N Eye Problems- Glaucoma
- Y N Alcohol abuse
- Y N Drug Abuse

SMOKING/TOBACCO USE
- Y N Do you smoke/use tobacco
  Packs/Day/Year _____

WOMEN
- Y N Are you pregnant
- Y N Using Birth Control
- Y N Are you nursing

ALLERGY: Are you allergic/had a reaction to:
- Y N Aspirin
- Y N Codeine
- Y N Dental Anesthetic
- Y N Erythromycin
- Y N Jewelry
- Y N Latex
- Y N Metals
- Y N Penicillin
- Y N Tetracycline
- Y N Others _____

Please list your medications (Rx, Herbal,OTC):

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

Hospitalizations: _____

_____

_____

Other conditions, otherwise not listed:

_____

_____

_____ _____

Signature of Patient, Parent/Guardian **Date**

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Consent for Use and Disclosure of Health Information

Patient Name Giving Consent: _____

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Privacy Practices is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Periodontal Offices, PC, Diane Harris, contact person. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation. We may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____ _____

****Signature of Patient/Responsible Party**** Date

If this Consent is signed by a Parent, Guardian, or Personal Representative (PR) on behalf of the patient, complete the following:

Parent, Guardian or PR's name: _____

Relationship to Patient: _____ Date: _____

Revocation of Consent-Sign only if Patient wishes to revoke their Consent
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ _____

****Signature of Patient/Responsible Party**** Date

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Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we created and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and supplying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information and treatment purposes: A nurse obtains treatment information about you and records it in a treatment record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of uses of your health information for payment purposes: We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding dental care provided. We will provide information to them about you and the care provided.

Example of use of your information for health care operations: We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol, and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS: The health record we maintain, and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- Request that you be allowed to inspect and copy your health and billing records—you may exercise this right by delivering the request in writing to our office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will **not** include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal hours. S(he) will provide you with assistance on the steps to take to exercise your rights.

OUR RESPONSIBILITIES:

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices regarding information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT:

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office administrator.

Additionally, if you believe your privacy rights have been violate, you may file a written complaint at our office by delivering the written complaint to our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and email address is: **200 Independence Ave. S.W., Washington DC., 20201; Phone # 1-877-696-6775;** http://HHS.gov

- We CANNOT and WILL NOT, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We CANNOT and WILL NOT retaliate against you for filing a complaint with the Secretary.

OTHER DISCLOSURES AND USES:

- **Notification:** Unless you object, we may use or disclose your protected health information, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
- **Communication with Family:** Using our best judgement, we may disclose to a family member, other relative, or close personal friend you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
- **Food and Drug Administration (FDA):** We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
- **Workers Compensation:** If you are seeking compensation through Workman's Compensation, we may disclose your protected health information to the extent necessary to comply with laws to Workman's Compensation.
- **Public Health:** As required by law, we may disclose your protected health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **Abuse & Neglect:** We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
- **Correctional Institutions:** If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.
- **Law Enforcement:** We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.
- **Health Oversight:** Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.
- **Judicial/Administrative Proceedings:** We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
- **Consent to Dental Photography:** We may take photographs and/or video of your face, jaws and teeth before, during, and after treatment. Your name or other identifying information will be kept confidential.
- **Electronic Forms of Communication:** We may communicate with you electronically at the email address and/or mobile phone numbers you have provided. There is some level of risk that third parties might be able to read unencrypted emails. You may withdraw your consent to electronic communications at any time by calling us at: (402)483-7631 or email at: info@pioneerperiodontics.com
- **Other Uses:** Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.
- **Website:** if we maintain a website that provides information about our entity, this Notice will be on the website.

I, _____, hereby acknowledge that I have received a copy of this practice's Notice and Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Name:_____ Date:_____

Revised – 10-2020