PATIENT REGISTRATION

Patient legal name: _____

Preferred name (if other than legal name): _____

Have you previously been seen in our office? _____ Y / N

Address: _____
Street Address City State Zip Code

Phone Numbers: (home) (work) (cell)

Email Address: _____

Gender M / F Social Security #: _____ Date of Birth: _____

Employer / Occupation: _____ Age: _____

Emergency contact name & phone: _____

If patient is a minor, name of parent accompanying minor: _____

General Dentist: _____ Are you covered by dental insurance? _____ Y / N

Primary Dental Insurance Information
Insurance Co.:
Group #:
Phone #:
Subscriber:
Employer:
ID number:
Date of Birth:
Relationship to patient:
If subscriber's address is different than patient's address, please list:

Secondary Dental Insurance Information
Insurance Co.:
Group #:
Phone #:
Subscriber:
Employer:
ID number:
Date of Birth:
Relationship to patient:
If subscriber's address is different than patient's address, please list:

Statement of Privacy Practice — U Village Endodontics

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act of the State of Washington. This includes issues relating to your treatment, payment, and our dental operations. Your personal health information will never be otherwise given to anyone-even your family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Please continue on other side. ⇨ ⇨ ⇨

Collecting Protected Health Information
We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Personal Health Information
As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and / or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards.

Patient Rights
You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associated, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in the amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices:
I have read this office's Notice of Privacy Practices and understand I can request a copy at any time.

Printed Name and Date: _____

Signature and Date: _____

Parents and Guardians:

I, _____, am the "personal representative" and have legal authority to make healthcare decisions about the following patient: _____

Authorization for Additional Disclosure:
In addition to the allowable disclosures in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the person(s) indicated below:
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Signature and Date: _____

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (please specify) _____