PATIENT INFORMATION

First Name _____ Last Name _____

What name does the patient go by? _____ Gender _____

Birth Date, Month _____ Day _____ Year _____ SSN _____

Email Address _____

Phone # _____ ⬜ Home ⬜ Mobile Work # _____

Mailing Address _____

City _____ State _____ Postal Code _____

Who is filling out the form? ⬜ Patient ⬜ Other Relationship to Patient _____

Please provide your first and last name _____

Phone # _____ Who has legal custody of the patient? _____

Who should we contact for scheduling?

Primary Contact Name _____

Phone # _____ Relationship to Patient _____

Primary Contact Address _____

City _____ State _____ Postal Code _____

How did you hear about us? _____

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Is the patient also the guarantor? ⬜ Yes ⬜ No

Guarantor First Name _____ Last Name _____

Phone # _____ Relationship to Patient _____

Guarantor Address _____

City _____ State _____ Postal Code _____

PATIENT EMPLOYMENT DETAILS, if applicable

Occupation _____ How long? _____

Employer/Company Name _____

Please list 2 contact names to whom practice can release information (HIPAA).

I. First Name _____ Last Name _____

Phone # _____

II. First Name _____ Last Name _____

Phone # _____

EMERGENCY CONTACT

First Name _____ Last Name _____

Phone # _____

SIGNATURE _____ DATE _____

ROAM DENTAL

MEDICAL HISTORY

▢ Yes	▢ No	Allergy - Aspirin	▢ Yes	▢ No	Allergy - Codeine
▢ Yes	▢ No	Allergy - Latex	▢ Yes	▢ No	Allergy - Penicillin
▢ Yes	▢ No	Allergy - Local Anesthetic	▢ Yes	▢ No	Allergy - Sulfa

List any other allergies _____

▢ Yes	▢ No	Abnormal (High/Low) Blood Pressure	▢ Yes	▢ No	AIDS / HIV
▢ Yes	▢ No	Anemia / Bleeding Problems	▢ Yes	▢ No	Artificial Heart Valves
▢ Yes	▢ No	Blood Disease	▢ Yes	▢ No	Heart Problems
▢ Yes	▢ No	Congenital Heart Lesions	▢ Yes	▢ No	Pacemaker
▢ Yes	▢ No	Arthritis / Rheumatism / Gout	▢ Yes	▢ No	Artificial Joints / Bone
▢ Yes	▢ No	Asthma	▢ Yes	▢ No	Cancer
▢ Yes	▢ No	Emphysema	▢ Yes	▢ No	Chemotherapy
▢ Yes	▢ No	Shortness of breath, breathing problems	▢ Yes	▢ No	Radiation Treatment
▢ Yes	▢ No	Diabetes	▢ Yes	▢ No	Glaucoma
▢ Yes	▢ No	Sinus Trouble	▢ Yes	▢ No	Stroke
▢ Yes	▢ No	Thyroid Problems	▢ Yes	▢ No	Tuberculosis
▢ Yes	▢ No	Tumor / growth on head / neck	▢ Yes	▢ No	Ulcer
▢ Yes	▢ No	Epilepsy	▢ Yes	▢ No	Fainting / Dizziness
▢ Yes	▢ No	Headaches (Frequent)	▢ Yes	▢ No	Hepatitis
▢ Yes	▢ No	Herpes	▢ Yes	▢ No	Kidney Disease
▢ Yes	▢ No	Liver Disease	▢ Yes	▢ No	Nervous Problems
▢ Yes	▢ No	Psychiatric Care			

List any other medical issues _____

List any serious Illnesses/surgeries/hospitalizations _____

_____

Are you taking any medications? ⬜ Yes ⬜ No

List medications _____

Smoker ⬜ Yes ⬜ No Do you drink alcohol? ⬜ Yes ⬜ No High Sugar Intake ⬜ Yes ⬜ No

Is the patient physically, mentally or emotionally impaired? ⬜ Yes ⬜ No

Is the patient under the care of a physician? ⬜ Yes ⬜ No

Physician Name _____ **Phone #** _____

For Females: Pregnant ⬜ Yes ⬜ No Nursing ⬜ Yes ⬜ No

SIGNATURE _____ **DATE** _____

ROAM DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____ Phone # _____

Address _____

Email _____

SECTION B: TO THE PATIENT, PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice.

Office Contact Information: Roam Dental, 47766 Van Dyke Ave., Shelby Twp., MI 48317
Phone number: 586-500-7626 Email: management.roamdental@gmail.com

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 the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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 _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF 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 _____ Date: _____

ROAM DENTAL

FINANCIAL POLICY

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered, unless financial arrangements are made.

All dental services are charged directly to the patient, and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

This office cannot render services on the assumption that our charges will be paid by an insurance company.

Payment for services is due at the time of treatment, or if billed by this office, payment is **due within thirty (30) days of billing**. Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

It is YOUR responsibility to check which services are covered under your insurance plan. Please understand that:
1. Your insurance policy is a contact between you, your employer, and the insurance company. Our relationship is with you, **NOT** with your insurance carrier.
2. All charges are **YOUR** responsibility whether your insurance company pays or not.
3. If the insurance company does not pay our balance within 60 days, we may ask you to contact them to request prompt payment. Please inform the office of their response. Please communicate any problems to us so that we can assist you in the management of your account.

INSURED/UNINSURED DISCLAIMER

Financial Disclaimer, for patients **WITH insurance:
As consistent with applicable laws and the terms of your dental insurance or other dental plan coverage:

Payment for services rendered will be due at the time of service.
The insurance portion of the treatment plan is an estimate and not a guarantee of coverage.
Your estimated portion will be due at the time of service.
If your insurance carrier pays less than the anticipated amount, you will be responsible for the unpaid balance.

I understand that I may be responsible for any unpaid balance for the procedures that are performed.

Financial Disclaimer, for patients **WITHOUT insurance:

Payment for services rendered will be due at the time of service.

I understand that I am responsible for all charges incurred during the course of my treatment.

SIGNATURE _____ **DATE** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/01/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider 2 performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose some health information to provide you with appointment reminders (such as text messages, voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $10 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Office Contact Information: Roam Dental, 47766 Van Dyke Ave., Shelby Twp., MI 48317
Phone Number: 586-500-7626 Email Address: management.roamdental@gmail.com

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ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

To comply with one of HIPPA's requirements, we are giving you a copy of our privacy practices.

Do you acknowledge that you have today received a copy of our notice of privacy practices? ⬜ Yes ⬜ No

Do you consent to our disclosure of your information that we deem necessary in order to provide you with proper treatment?

⬜ Yes ⬜ No

I have received a copy of this office's Notice of Privacy Practices

PRINT NAME _____

SIGNATURE _____ **DATE** _____

FOR OFFICE USE ONLY

Roam Dental attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

⬜ Individual refused to sign
⬜ Communications barriers prohibited obtaining the acknowledgement
⬜ An emergency situation prevented us from obtaining acknowledgement

⬜ Other (Please Specify) _____