Patient Name: _____

Today's Date:_____/_____/_____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

FIRST NAME_____ LAST NAME_____ SOC. SEC. #_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ HOME PHONE_____

CELL PHONE_____ EMAIL_____

SEX ☐ M ☐ F AGE_____ BIRTHDATE_____ ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

PATIENT EMPLOYED BY_____ OCCUPATION_____

BUSINESS ADDRESS_____ BUSINESS PHONE_____

BUSINESS EMAIL_____

HOW DID YOU FIND US?_____

NOTIFY IN CASE OF EMERGENCY_____ HOME PHONE_____

CELL PHONE_____ BUSINESS PHONE_____

EMAIL_____

Primary Insurance

SUBSCRIBER INFORMATION: FIRST NAME_____ LAST NAME_____

RELATION TO PATIENT_____ BIRTHDATE_____ SOC. SEC. #_____

ADDRESS (if different from patient)_____ HOME PHONE_____

CITY_____ STATE_____ ZIP_____

CELL PHONE_____ EMAIL_____

SUBSCRIBER'S EMPLOYER_____ OCCUPATION_____

INSURANCE COMPANY_____ PHONE_____

SUBSCRIBER ID/MEMBER ID#_____ GROUP #_____

Secondary Insurance (if applicable)

SUBSCRIBER INFORMATION: FIRST NAME_____ LAST NAME_____

RELATION TO PATIENT_____ BIRTHDATE_____ SOC. SEC. #_____

ADDRESS (if different from patient)_____ HOME PHONE_____

CITY_____ STATE_____ ZIP_____

CELL PHONE_____ EMAIL_____

SUBSCRIBER'S EMPLOYER_____ OCCUPATION_____

INSURANCE COMPANY_____ PHONE_____

SUBSCRIBER ID/MEMBER ID#_____ GROUP #_____

Patient Name: _____

Today's Date: ____/____/____

KenCarylDentalCenter

Dental History

WHAT WOULD YOU LIKE US TO DO TODAY? _____ ARE YOU IN DENTAL DISCOMFORT? _____

FORMER DENTIST _____ ADDRESS _____

FORMER DENTIST PHONE _____ DATE OF LAST VISIT _____ DATE OF LAST X-RAYS _____

Check (✔) yes or no if you have had problems with any of the following: REASON FOR VISIT _____

☐Y ☐N Bad breath ☐Y ☐N Food collection between teeth ☐Y ☐N Periodontal treatment ☐Y ☐N Sensitivity to sweets

☐Y ☐N Bleeding gums ☐Y ☐N Grinding or clenching teeth ☐Y ☐N Sensitivity to cold ☐Y ☐N Sensitivity when biting

☐Y ☐N Clicking or popping jaw ☐Y ☐N Loose teeth or broken fillings ☐Y ☐N Sensitivity to hot ☐Y ☐N Sores or growths in mouth

HOW OFTEN DO YOU BRUSH? _____ FLOSS? _____

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? _____

HAVE YOU EVER EXPERIENCED AN ADVERSE REACTION DURING OR IN CONJUNCTION WITH A MEDICAL OR DENTAL PROCEDURE? ☐Y ☐N

OTHER INFORMATION ABOUT YOUR DENTAL HEALTH OR PREVIOUS TREATMENT

_____

_____

Medical History

PHYSICIAN'S NAME _____ PHONE _____

PHYSICIAN'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF LAST VISIT _____ HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? ☐Y ☐N

IF YES, DESCRIBE _____

ARE YOU CURRENTLY UNDER PHYSICIAN CARE? ☐Y ☐N IF YES, DESCRIBE _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐Y ☐N IF YES, GIVE APPROXIMATE DATES _____

HAVE YOU EVER TAKEN "Fen-Phen/Redux"? ☐Y ☐N

HAVE YOU EVER USED A BISPHOSPHOONATE MEDICATION? Brand names include Fosamax, Actonel, Atelvia, Didronel, and Boniva. ☐Y ☐N

WOMEN: ARE YOU PREGNANT? ☐Y ☐N NURSING? ☐Y ☐N TAKING BIRTH CONTROL PILLS? ☐Y ☐N

LIST OF MEDICATIONS

_____

_____

_____

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LIST OF ALLERGIES

_____

_____

_____

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_____

Patient Name:

_____

Today's Date:_____/_____/_____

Medical History (cont'd)

Check (✔) yes or no whether you have had any of the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotherapy
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Drink alcohol
How much?_____
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe_____
☐Y ☐N Hemophilia/ Abnormal bleeding
☐Y ☐N Herpes
☐Y ☐N Hepatitis
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Liver disease
☐Y ☐N Marijuana habit
How much?_____
☐Y ☐N Material allergies (**latex**, wool, metal, chemicals)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Nervous problems
☐Y ☐N Pacemaker/ Heart surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N Shingles
☐Y ☐N Shortness of breath
☐Y ☐N Skin rash
☐Y ☐N Spina Bifida
☐Y ☐N Stroke
☐Y ☐N Surgical implant
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Tobacco/Vape habit
How much?_____
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Ulcer/Colitis
☐Y ☐N Venereal disease

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signatures_____ Date_____

KenCarylDentalCenter

Alan C. Goral, D.D.S.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I have read and received a copy of the financial guidelines and I agree to the terms.

ASSIGNMENT OF BENEFITS

If I have insurance coverage on the date of service, I assign directly to Alan C. Goral, D.D.S. all insurance benefits. I authorize the use of my signature on all insurance claim submissions.

RELEASE OF INFORMATION

If I have insurance coverage, I authorize release of any medical information necessary to process all present and future claims.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient signature Date

Please print name

10789 Bradford Rd., Suite 100, Littleton, CO 80127 303.933.2273 KenCarylSmiles.com

KenCarylDentalCenter

CONSENT TO DISCLOSE INFORMATION

I, _____, hereby give my consent for the following individuals to schedule my treatment, discuss my treatment, and handle my finances concerning my dental treatment at Ken Caryl Dental Center:

Full Name: _____ Relationship:_____

Exclusions, if any:_____

Full Name: _____ Relationship:_____

Exclusions, if any:_____

Full Name: _____ Relationship:_____

Exclusions, if any:_____

This authorization will remain in effect until I notify Ken Caryl Dental Center that I want to make changes or rescind.

Patient Signature:_____ Date:_____

KenCarylDentalCenter

Financial Guidelines

Thank you for choosing Dr. Goral and Dr. Rand for your dental needs. We strive to provide the highest quality, comprehensive dental care to you and your family. Prior to beginning treatment, we would like to explain our financial policy and payment options.

As necessary treatment is diagnosed, a treatment plan worksheet will be created for your review. Our fees will be clearly noted as well as an estimate of expected dental benefits if you have dental insurance. **You will be responsible for the balance at the time the services are performed.**

We submit all insurance claims electronically to ensure the highest level of speed and accuracy. **Please remember that insurance coverage is a contract between you, the policy holder, and the insurance company, and in most cases has been negotiated by an employer.** If your insurance company denies benefits for any reason, you are responsible for the entire amount of the balance.

The following payment options are designed to provide you with choices to help make the quality dental care that we provide as affordable as possible.

☐ **Cash, check or credit card (Visa, MC, Discover or AmEx) payment in full at time of service.**

☐ **Quality Dental Plan, our in-house savings plan if you do not have insurance.**

☐ **5% discount for prepayment in full, before the day of your appointment.**

☐ **Partial payments if amount is over $600. A signed financial agreement is required to spread payments over 2 or 3 months.**

☐ **CareCredit® or CitiHealth Card® Payment Plan* Flexible financing options, quick and easy application.**

*Subject to credit approval. See patient brochure for promotional information and estimated monthly payments.

Missed/Broken appointments: A specific block of time is reserved especially for you and we expect patients to keep their appointments. If you have to change your appointment, we require notice of 24 hours and at least one business day to avoid a charge of $25 per half hour missed appointment fee.

We will charge a rebilling fee of $10 per month if your account remains unpaid for a second billing cycle after your insurance has paid.

10789 Bradford Rd., Suite 100, Littleton, CO 80127 303.933.2273 KenCarylSmiles.com

KenCarylDentalCenter

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 1, 2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI
Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights
Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Becky Tyler

Telephone: 303.933.2273 Fax: 303.933.0183 E-Mail: frontdesk@KenCarylDental.com 10789 Bradford Rd., Ste 100, Littleton, CO 80127