Patricia L. Carlson, DDS, MPH
Parrish Dental Care, PLLC

Form 1: Patient Registration

Name			
Address		City/State/Zip	
Home phone		Work phone	
Cell phone		Email address	
Birth date		Sex ☐ M ☐ F	
Marital status	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Person to call in case of emergency			Phone
Person responsible for account			Phone
Address		City/State/Zip	
Patient's place of employment and address			
Spouse's name		Spouse's work phone	
Spouse's place of employment and address			
Name(s) and age(s) of dependent(s)			

If patient is a child:

Parent's name
Father's place of employment, work phone and work address
Mother's place of employment, work phone and work address

Payment is due at time of service. Please indicate preferred method:			☐ ***Cash*** ☐ ***Check/Debit***
☐ ***MasterCard***	☐ ***Visa***	☐ ***Discover***	☐ ***American Express***

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Do you have dental insurance?	☐ Yes	☐ No
Insured's name	Insured's date of birth	
Name, address and phone of insurance company		
Insurance contract number (if none, then insured's Social Security number)		Group number
Are you covered under a spouse's or secondary dental plan?		☐ Yes ☐ No
If yes, name, address and phone of secondary insurance company		
Secondary insurance contract number (or insured's Social Security number)		Group number
Whom can we thank for referring you to our office?		

I authorize Patricia L. Carlson, DDS, MPH to provide any insurance company(s), claim administrator(s) and consulting health care professionals information concerning health care, advice, medication, treatment or other services provided to me. This information will be used to evaluate and administer claims for benefits.
This authorization is valid for the term of coverage of the policy or contract, in force on this date only, or for two years, whichever is sooner.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature of patient or authorized person	Date

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are true or to leave out facts I know are important (NYS Insurance Law 38, 176 Reg. No. 95).

Signature of patient or authorized person	Date

If authorizations to pay third party benefits are indicated on this form:
Appropriate authorizations to pay signed by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determination as to the release of dental and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The provider agrees to hold harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid authorization to pay benefits to the provider was made.

Form 3: Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review this notice carefully.

Compliance with the federal Health Insurance Portability & Accountability Act of 1996 (HIPAA) became mandatory on April 14, 2003. HIPAA 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. This Act gives the patient significant new rights to understand and control how his or her health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

This office pledges to use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would be a referral to a specialist.

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 individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing; 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 regarding your protected health information, which you can exercise by presenting a written request to this office's privacy officer:

Form 3: Notice of Privacy Practices Continued

- 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 not required, however, 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 alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain – and we have the obligation to provide to you – a paper copy of this notice from us on the first date we provide service to you.

- The right to provide – and we are obligated to receive – a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

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 regarding protected health information.

As of April 14, 2003, 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 our 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 the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Patricia L. Carlson, DDS, MPH
Parrish Dental Care
191 Parrish St.
Canandaigua, N.Y. 14424-1726
585-394-0710

For more information about HIPAA or to file a complaint:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, D.C. 20201
202-619-0257

Form 4: Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this 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 directly or indirectly involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 address below to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private 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 that if you do agree then you are bound to abide by such restrictions.

Patient name
Relationship to patient
Signature
Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason

Form 5: Authorization to Release Health Care Information

Once this form is completed – please forward to your previous dentist to ensure that your records are transferred prior to your first appointment.

Patient name	Birth date	
Previous name, if any		
Doctor's name		
Practice name		
I request and authorize the above listed doctor and practice to release health care information of the patient named above to:		
Name **Patricia L. Carlson, DDS, MPH**		
Address **191 Parrish St.**		
City **Canandaigua**	State **N.Y.**	Zip code **14424-1726**
This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:		
Or ☐ All health care information		
Or ☐ Other		
This authorization expires on	**or**	**days after the date it**
is signed, or when the following event occurs:		

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice called **Revocation of Authorization for Use and Disclosure of Health Care Information** or
- Write a letter to the doctor or practice, saying that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) whom I no longer want to receive information. I or my authorized representative must sign and date the letter.

I know that, once my doctor releases the information as I authorized, he or she has no control over that information. The individual or organization that I authorized to receive the information might redisclose it. Federal or state privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative	Date
If signed by representative, indicate relationship (parent, legal guardian, etc.)	

Form 6: Patient Disclosure Instructions

The privacy rule of the Health Insurance Portability & Accountability Act of 1996 (HIPAA) gives an individual the right to request a restriction on uses and disclosures of his or her protected health information.

The rule also gives the individual the right to request that communication be confidential, and that communication be made by alternative means if requested – by contacting his or her workplace, for example, rather than his or her home.

I wish to be contacted in the following manner *(check all that apply)*. I am providing phone numbers and addresses where applicable:	
☐ **Home phone number:**	☐ **Cell phone number:**
☐ O.K. to leave message with detailed information	☐ O.K. to leave message with detailed information
☐ Leave message but provide call-back number only	☐ Leave message but provide call-back number only
☐ **Work phone number:**	☐ Written communication
☐ O.K. to leave message with detailed information	☐ **O.K. to email to:**
☐ Leave message but provide call-back number only	☐ **O.K. to mail to my home address:**
	☐ **O.K. to mail to my work address:**
☐ **Other:**	

I authorize you to give my clinical information to or to answer questions from (c*heck all that apply*):				
☐ Spouse	☐ Parent	☐ Child	☐ Other (specify)	☐ None

Patient name	Birth date
Patient signature	Date signed