WELCOME

We appreciate you trusting us to care for your dental and sleep medicine needs. Please fill out the following completely. If you have any questions, just ask – we are here to help!

PATIENT INFORMATION Date: ______________________________

Name: ____

Address: ____ ______________ City: ______________________________

State: __________ Zip: _______________________ Email: ____

Home Phone: _______________________Work phone: ______________________ Cell Phone: _______________________

Sex: □ Male □ Female Age: ________ DOB: _____________________ Soc. Sec. # ____________________________

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Whom may we contact in case of emergency? Name: _____________________________ Ph # _________________________

How did you hear about us? ____

What is your preferred method for us to contact you? □ Cell □ Work □ Home □ Email □ Text □ Other __________

PRIMARY INSURANCE INFORMATION:

Name of Insured: ____ Relation to patient: ______________________

Address: _________________________________ City: __________________ State: ___________ Zip: _____________

Employed by: ____

Insurance Company Name: ___________________________ Address: ____

City: _____________________________________ State: ______________________ Zip: ________________________

Group # __________________________________ Member ID or Soc Sec # _____________________________________

Dependents covered by this plan: ____

SECONDARY INSURANCE INFORMATION:

Name of Insured: ____ Relation to patient: ______________________

Address: _________________________________ City: __________________ State: ___________ Zip: _____________

Employed by: ____

Insurance Company Name: ___________________________ Address: ____

City: _____________________________________ State: ______________________ Zip: ________________________

Group # ___________________________________ Member ID or Soc Sec # ____________________________________

Dependents covered by this plan: ____

Please complete both sides

DENTAL HEALTH HISTORY

Reason for today's visit: ____

Previous Dentist: ______________________ Ph #: ______________________

Date of last dental visit: ____________________ Last Dental X-rays: ________________

Please check (√) if you have had trouble with any of the following:

□ Bad Breath	□ Bleeding gums	□ Clicking or Popping Jaw	□ Food collection between teeth
□ Grinding teeth	□ Loose teeth or broken fillings	□ Periodontal treatment	□ Sores or Growths in Mouth
□ Sensitivity to cold	□ Sensitivity to heat	□ Sensitivity to sweets	□ Sensitivity when biting

How often to you brush? _______________ How often to you floss? __________________

MEDICAL HISTORY

Physician's Name: ______________________ Date of last visit: ____________________

Previous hospitalizations/illnesses: (please describe and give approximate date): ____________________

____

WOMEN: Are you pregnant: □ Yes □ No Nursing: □ Yes □ No Taking birth control pills? □ Yes □ No

Please check (√) if you have had trouble with any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Aids	□	□	Circulatory Problems	□	□	Hepatitis	□	□	Radiation Treatment
□	□	Anemia	□	□	Cough, persistent	□	□	High Blood Pressure	□	□	Respiratory Disease
□	□	Arthritis, Rheumatism	□	□	Diabetes	□	□	HIV Positive	□	□	Rheumatic Fever
□	□	Artificial Heart Valves	□	□	Epilepsy	□	□	Jaw Pain	□	□	Shortness of Breath
□	□	Artificial Joints	□	□	Fainting	□	□	Kidney Disease	□	□	Skin Rash
□	□	Asthma	□	□	Glaucoma	□	□	Liver Disease	□	□	Stoke
□	□	Back Problems	□	□	Headaches	□	□	Mitral Valve Prolapse	□	□	Thyroid Problems
□	□	Blood Disease	□	□	Heart Murmur	□	□	Nervous Problems	□	□	Tobacco Habit
□	□	Cancer	□	□	Heart Problems:	□	□	Osteoporosis	□	□	Tonsillitis
□	□	Chemical Dependency			Describe: ______________	□	□	Pacemaker	□	□	Tuberculosis
□	□	Chemotherapy	□	□	Hemophilia	□	□	Psychiatric Care	□	□	Ulcer

Other: ____

Allergies to medications: ____

Have you ever taken any type of Osteoporosis medications? □ Yes □ No

If Yes, please list: ____

Please list all medications you are currently taking: ______________________________

or - □ SEE ATTACHED LIST

AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur. I also agree to complete full periodic health history updates when asked.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize the use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that this office cannot guarantee insurance benefits or payment from any insurance company. It is my responsibility to provide current insurance benefit information and to be aware of its coverage and limitations. I agree to be responsible for payment of all services rendered on my behalf.

Signature: ______________________________ Date: ____________________

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

CONSENT TO PERFORM TREATMENT

You have the right to be informed of your condition and the recommended treatment plan so that you may make an educated decision as to whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is *not meant to alarm you*, but is rather an effort to provide information so that you may give or withhold your consent.

________ **RISKS**: I understand that there are certain inherent and potential risks and side effects associated with my proposed treatment which include, but are not limited to:

- Post-operative discomfort and swelling that may require several days of recovery
- Injury or damage to adjacent teeth and fillings
- Post-operative infection that may require additional treatment
- Dry socket (loss of blood clot from extraction site) often requiring additional treatment
- Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue and which may persist for several weeks, months or in rare instances - permanently.
- Anesthetic Risks include discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. Nausea and vomiting, although uncommon may be unfortunate side effects. Anesthesia has systemic effects and, although considered safe, does carry with it the rare risks of heart irregularities, heart attack, stroke, brain damage and even death.
- Allergic reactions (previously unknown) to any medications used in treatment

________ I understand that during the course of treatment unforeseen conditions may be revealed that may require changes in the procedure noted in the treatment plan presented. I authorize Dr. Hansen and his staff to use professional judgment to perform such additional procedures necessary to complete my treatment.

_______ I have been given a treatment plan with possible options available to me, and have been informed of the general nature of such treatment.

_______ The procedures to be performed have been satisfactorily explained to me, and I have had the opportunity to ask any questions that I may have regarding my treatment, and have had such questions answered to my satisfaction before commencing treatment.

I understand the risks related to dental treatment and consent to such treatment performed by Gerald V. Hansen, D.D.S., and/or his staff.

______________________________________ ______________________________________

Name of patient (PRINT) Signature of patient (or guardian of patient)

____

Date

GERALD V. HANSEN, D.D.S.
PAYMENT REQUIRMENTS AND OFFICE POLICIES

PAYMENT: **Payment is required at time of service.** If there is no insurance, we do offer a discount. This does not include any products, such as bleaching. We also have a discount plan available if you do not have any type of insurance.

INSURANCE: **If you have insurance, we require that your entire estimated portion is paid at time of service.** As a courtesy, we will *submit* your insurance for you if you live locally, you can supply a State I.D., and insurance coverage in effect. ***We must be able to verify coverage with the actual insurance company***. If we cannot, you can still keep your appointment, however you will need to pay for the visit yourself. ***Your insurance is a contract between you, your employer, and the insurance company.*** We are NOT a party to that contract. We cannot guarantee payment from any insurance company. ***It is your responsibility to know the benefits and limitations of your plan.*** It is also your responsibility to pursue the payment from your insurance company if they do not pay your bill. If for any reason, your insurance does not pay, you are responsible for the entire amount. **We can only estimate what your insurance will pay**. There is no way of knowing exact amounts until we get the actual check from the insurance company.

APPOINTMENTS: You are responsible for your appointments. We use text, email, or voice messaging to "confirm" your appointments. We can use whichever preference you like. Your appointment times reserved specifically for you, so please make sure that you confirm with us that you are coming. **There will be a cancellation/no show fee charged** if you do not call within ***48 "office" hours*** of your appointment to cancel. ***Calls must be made to us (not the voicemail or text) to cancel or reschedule Mon-Thurs 8am-5pm***, as our office is closed Friday through Sunday.

This office only does composite fillings. Most insurance companies do not pay for composite (white) fillings, however they will pay at an amalgam (silver) allowance. That difference is the patients' responsibility.

To be respectful of our time and other patients and our office, please **turn your cell phone off or on silent**.

Original x-rays are a permanent part of your record and by law must stay with our office. We will be happy to provide copies of the x-rays at no charge if requested.

There will be a fee for each time a check is returned for whatever reason.

Any unpaid balance will accrue monthly interest. If we need to pursue the payment of your bill, you will be responsible for any collection and/or attorney fees that are incurred.

I have read and understand the above statements.

Patient (or parent) signature____ Date __________________

This office has my authorization to email my x-rays to other doctors referred by this office for treatment purposes. (We use encrypted email services).
Signature: ____

_______ (INITIAL) I authorize Dr. Hansen to use his personal cell phone to contact me regarding treatment

_______ (INITIAL) If my blood or any instruments used on me come into contact with a member of the staff, I will agree to a blood test.

V.N. HANSEN DDS LTD
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 September 23, 2013, 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:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o 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: Carla M. (office manager) E-mail: carla@hansendds.net Secondary email: info@hansendds.net

Telephone: (775) 329-0500 Fax: (775) 329-4608 Address: 475 S. Arlington Ave. Suite 1B, Reno, NV 89501

Acknowledgement of Receipt of Notice of Privacy Practices

V.N. HANSEN DDS LTD

* You May Refuse to Sign This Acknowledgment*

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

Print Name:____

Signature:____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

___AUTHORIZATION FOR DISCLOSURE___

*(THIS IS A **VOLUNTARY** FORM)*

Use this form only if there is someone (including immediate family members) who will be calling on your behalf to discuss any information on you, or make appointments for you. Under the privacy laws, we need to know WHO you will allow us to speak to about your information. ***This does not include any doctors, pharmacies, or government agencies.*** *If there is no one you would like to designate, just leave the form blank.*

I authorize Gerald V. Hansen, D.D.S. and/or his staff to disclose information about myself in the following areas to the person(s) below.

(Please check all that apply, OR all of the above)

___ Appointments

___ Performed procedures

___ Medications given/prescribed

___ Medical / Dental Concerns & Health History

___ Treatment plans

___ Insurance

___ Financial obligations (billing)

OR ___ All of the above

I give authorization to disclose my information in the above instances to:

________________________________ ________________________________
name of person relationship to you

________________________________ ________________________________
name of person relationship to you

________________________________ ________________________________
name of person relationship to you

Patient signature: ________________________________Date: __________

Print name: ________________________________

(This is a legally binding document once signed.)

You may advise us at anytime in writing that you want to change or revoke this form.