LAS CRUCES DENTAL ASSOCIATES, PC

PATIENT INFORMATION **PLEASE PRINT**

Name _____ **Date of Birth**_____

Mailing Address _____**City** _____**Zip Code**_____

Phone (___)_____**Work Phone ( )**_____**Ext**___ **Cell ( )** _____

EMAIL_____**SS#** _____/_____/_____

Spouse's Name - _____**wk#_( )**_____

RESPONSIBLE PARTY for Account-

Name _____**Date of Birth**_____ **SS#-** _____

Mailing Address _____**City** _____**Zip Code**_____

Employer Name _____**Dept.**_____

Phone (___) _____ **Work Phone :( )** _____**Ext**___ **Cell (___)** _____

Circle one: Spouse Parent Guardian Other_____

INSURANCE INFORMATION

PRIMARY	**SECONDARY**
Employee: _____	**Employee:** _____
Insurance Co. Name:_____	Insurance Co. Name_____
Employer Name:_____	Employer Name:_____
Address:_____	Address: _____
Policy/ID #_____ Group#_____	Policy/ID# _____Group#_____
SS# _____	SS # _____

Referred By: _____

Agreement of Payment: It is important you understand that payment is due at the time of service, if you have Dental Insurance we will file for you, however all co-pays, deductibles, and your percentage is due at the time of service. If you have used your dental insurance benefits elsewhere it is **your responsibility** to inform the front office staff so you will not go over your yearly maximum allowable.
Any amount over your maximum yearly allowable is your responsibility.

$50.00 cancellation fee will be charged if not notified within 48 business hours of appointment

Consent Form: I hereby freely and willingly consent to the performance upon: (Name of patient) _____of a course of dental treatment procedures, or procedures which may later become apparent during treatment. I acknowledge that no guarantee or assurance is made as the results that may be obtained.

Date _____Signature _____
(Patient) (Parent) (Legal Guardian)

HEALTH HISTORY

Do you have or have had any of the following:

Y	N		Y	N	
__	___	Acid Reflux	__	__	Headaches
__	___	AIDS	__	__	Heart Problems
__	___	Anemia	__	__	Heart Attack-when _____
__	___	Arthritis	__	__	Heart Murmur
__	___	Artificial Joints	__	__	Hepatitis- A___, B___, C___
__	___	Asthma	__	__	HIV
__	___	Bleeds easily	__	___	Kidney Problems
__	___	Blood Pressure- High	__	___	Liver Disease
__	___	Blood Pressure- Low	__	___	Rheumatic Fever
__	___	Cancer- Type_____	__	___	Sinus Problems
__	___	Difficulty Breathing	__	___	Sleep Apnea
__	___	Difficulty Sleeping	__	___	Thyroid Disease-_____
__	___	Epilepsy	__	___	TMJ Problems
__	___	Diabetes- Type _____			

Do you have allergies? Please mark with an "X"

__Aspirin ___Latex ___Penicillin ___ other
__Codeine ___Metal ___Sulfa _____

For Woman

Y	N		Y	N	
__	__	Are you pregnant? _____ Months	__	__	Taking birth control?
__	__	Are you nursing?	__	__	Taking hormones?

Please list any medications you are taking and why.

Medication	Reason

Medical History Reviewed and updated on:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

_____ Date _____
Patient / Parent / Legal Guardian

(575) 523-1479

LAS CRUCES DENTAL ASSOCIATES

2569 East Idaho Ave. * Las Cruces, NM 88011
(575) 523-1479 * Fax (575) 523-2974

HIPPA Notice of Privacy Act

Office Policy and Notice of HIPAA Privacy Practice

Thank you for choosing our practice for your dental health needs. Our goal is to provide quality care to all our patients with affordable fees. We are dedicated to making healthcare less stressful and more valuable by clarifying financial responsibilities in advance.

It is our office policy to bill your insurance carrier as a courtesy to you. Therefore, it is your responsibility to make sure we have current insurance information for you and your family. Ultimately any remaining balance not covered by your insurance is your responsibility. Payment may be made by CHECK, CASH, VISA, MASTERCARD, or DISCOVER. If unable to pay in full we offer CARE CREDIT financing. There is a returned check fee of $25.00 for all checks returned to us by the bank for insufficient funds.

Our office will be happy to make arrangements in advance of service for extensive dental treatment. There will be a charge of $50 for a broken or no-show appointment, with less than 48-hour notice and will require a deposit on the rescheduled appointment. This notice of Privacy Practice describes how we as health care providers may use and disclose your protected information to carry out treatment, payment and health care operations and for other purposes that are permitted or required by law. Protected Health Information (PHI) is information about you, including demographic information. That may identify you and that relates to your past, present and future physical or mental health or condition and related to health care services.

The Department of Health and Human Services has established a “Privacy Policy” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to assure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal

If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

2569 East Idaho Ave. * Las Cruces, NM 88011
(575) 523-1479 * Fax (575) 523-2974
www.lascrucesdental.net

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

_____
(Please 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:

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

_____
_____
_____
_____