Fenton Family Dentistry

Dr. Sarah L. Paxton, Dr. Kaitlin Monash, Dr. Melissa Royer
17197 Silver Parkway Fenton, MI 48430
P: 810.750.3600 F: 810.750.3821 E: fentonfamilydentistry@gmail.com

Patient Information Date _____

Patient's Name _____ Birthdate _____

Preferred Name:_____

Cell Phone _____Home Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse' Employer _____

Email Address _____

Would you like to receive text message notifications for appointments? Y N E-mail? Y N

BILLING, CREDIT, AND INSURANCE INFORMATION: Covered by dental insurance? Y N

Your Social Security number: _____ Gender _____

Dental Insurance Co._____ Group number _____

Covered by a parent or spouse/partner insurance? ( ) yes ( ) no

Spouse/partner's Dental Insurance Co. _____ Group number _____

Spouse/partner's birthday _____ Social Security number _____

In Case of Emergency, please contact:

Name _____ Phone # _____

Relationship _____

Please list anyone with whom we can share your medical information:

_____

_____

Consent for Treatment

1. I hereby authorize Dr. Paxton, Dr. Monash, Dr. Royer or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis.
2. Upon such diagnosis, I authorize Dr. Paxton, Dr. Monash, and Dr. Royer to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents, I understand that payment is due at the time of services unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge 9.18% APR) may be added to my account.

Signature: _____ Date: _____

Witness: _____ Date: _____

Parent or Responsible Party: _____

Relationship to Patient: _____

Dental History

Date_____

What is the reason for today's visit? _____

Date of last dental visit _____ Name/City of Previous Dentist _____

Please place check to indicate you have had any of the following:

Periodontal treatment _____ Dry mouth _____ Grinding teeth _____ Loose teeth _____

Orthodontic treatment _____ Broken fillings _____ Swollen gums_____ Bleeding gums_____

Sensitivity to hot _____ Sensitivity to sweets _____ Sensitivity to cold _____

Sensitivity to biting_____ Sores or growths in your mouth _____

How often do you brush?_____ Floss?_____

Are you currently having problems with dental pain or pain management? Y N

If so, on a pain scale of 1 - 5 with 5 being the worst 1 2 3 4 5

Health History

Physician's Name _____ Phone #_____

Date of Last visit _____

Are you currently being treated for any condition? Please describe _____

Do you have an allergy to:

____ Aspirin ____ Anesthetics ____ Penicillin ____Codeine ____ Sulfa ____ Iodine

____ Latex ____ Other (please list): _____

Have you **ever** taken / Are you currently taking any of the following?

Aspirin Anticoagulant/Blood thinner Antibiotics Steroids

Diabetes Medication Nitroglycerin Osteoporosis (bone density) Medication

Women:

Are you pregnant? Y N Expected delivery date: _____
Nursing? Y N Are you taking hormones or contraceptives? Y N

Have you had any surgeries or hospitalizations in the past two years? Y N
Please describe:_____

Please list all over the counter and prescription medications you are currently taking:

_____

_____

Please select Yes or No for each of the following:

AIDS/HIV	Y N	Epilepsy	Y N	Respiratory Problems	Y N
Anemia	Y N	Fainting/Dizzy	Y N	Rheumatic Fever	Y N
Arthritis	Y N	Glaucoma	Y N	Shortness of Breath	Y N
Artificial heart valves	Y N	Headaches	Y N	Sinus Trouble	Y N
Asthma	Y N	Heart Murmur	Y N	Skin Rash	Y N
Back Problems	Y N	Heart Probs.	Y N	Stroke	Y N
Bleeding Problems	Y N	Hepatitis	Y N	Swollen feet/hands	Y N
Cancer	Y N	type _____		Thyroid Problems	Y N
Chemical Dependency	Y N	High Blood Pressure	Y N	Tonsillitis	Y N
Chemotherapy	Y N	Jaundice	Y N	Tuberculosis	Y N
Circulatory problems	Y N	Jaw Pain	Y N	Tumor	Y N
Cough	Y N	Kidney Disease	Y N	Smoke	Y N
Diabetes	Y N	Liver Disease	Y N	Angina	Y N
Emphysema	Y N	Nervous Disorder	Y N	Artificial joint	Y N
Pacemaker	Y N	Psych. Care	Y N	Bruise easily	Y N
Radiation Treatment	Y N	Seizures	Y N	Osteoporosis	Y N

Have you ever had abnormal bleeding after extractions, surgery or trauma? Y N

Have you ever had any problems with dental treatment? Please explain:

_____

_____

Do you have any disease, condition or problem not listed above?

_____

_____

_____

Any Additional information:

_____

_____

_____

No Show and Cancelation Policy

I Acknowledge that if I do not show up to my appointment or cancel the same day as my appointment I am required to pay a $35 fee. I am aware that to avoid this fee I need to give notice at least one day in advance.

Patient/Guardian Signature:_____

Fenton Family Dentistry
Sarah Paxton, D.D.S. & Associates
17197 Silver Parkway
Fenton, MI 48430
(810) 750-3600

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 IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

There are many different ways that we may use medical information. For each type of use or disclosure we will explain what we mean and try to give an example. Not every use will be listed. However, all of the ways we are permitted to use and disclose information fall within one of the categories below. In this notice we use the term “health information” to include all of your personal and medical information that is applicable to your dental treatment (i.e. name, date of birth, previous and existing medical conditions, dental treatment history, etc.)

Treatment: Your health information may be shared with those people who are involved in your care. For example, Dr. Paxton may share your medical information with an Oral Hygienist who is assisting with your treatment. Or, the staff at Fenton Family Dentistry may share health information with your family member who may help with your care after you leave the office.

Payment: We may share information about the care you received so that it may be billed. For example, we may contact your dental insurance company about a treatment you are going to receive to determine your coverage.

Health Care Operations: We may use information about you for office operations. For example, we may review your health information to assess our services to improve the care at our office.

Appointment Notice: Our office may use information to contact you as a reminder that you have an appointment for treatment, including by mail and phone.

SPECIAL SITUATIONS:

We may disclose health information, including individually identifiable health information about you as required by State or Federal Laws and regulations relating to any or all of the following, as such may apply to you.

- Community/Public Health activities and reports such as disease control, abuse or neglect, and health and vital statistics.
- To avert a serious threat to your health or safety and to protect the health and safety of the public. Any disclosure would only be to someone able to help prevent or lessen the threat.

- Administrative oversight for such things as audits, investigations, licensure, or determining cause of death.
- Court Order or other legal processes related to law enforcement activities including custody of inmates, legal actions, or national security activities.
- To respond to lawsuits and legal actions in response to a Court or Administrative Order, or in response to a subpoena.
- Military and Veteran reporting on members of the armed forces of U.S. or foreign military as required by military command authorities.
- Workers' Compensation or other rehabilitative activities reporting as required by law or insurers in order provide benefits for work related or victim injuries or illnesses.

In addition to Federal law, we will also comply with all applicable State law. For example, under State law, there are more limits on the disclosure of HIV and AIDS information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights to health information we maintain about you. Please contact our office if you wish to discuss any of the options noted below.

Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes dental and billing records. We may charge a fee for the costs of copying, mailing or other supplies related to your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, we will respond to you timely in writing and explain the reasons for our denial. You may request that the denial be reviewed by a licensed health care professional who was not directly involved in the denial decision.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office. Please contact our office if you would like to discuss an amendment to your health record.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If your request is denied we will explain the reason for the denial to you in writing within 60 days of your request. In addition, we may deny your request if you ask us to amend the information that:

- Was not created by Fenton Family Dentistry, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for Fenton Family Dentistry;
- Is not part of the information which you would be permitted to inspect and copy; or ● Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of health information about you. Your request must state a time period, which may not be longer than the past six years. The first list your request within a 12-month

Rights to an Accounting of Disclosures. You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of health information about you. Your request must state a time period, which may not be longer than the past six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request limits on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example you could ask that we not use or disclose information about a procedure that you had at Fenton Family Dentistry. For all requests unless the information is needed to provide you emergency care.

We are not required by Federal regulation to agree to your request for restrictions, except when you ask us not to disclose information to your dental plan about a service that you have paid in full, out of pocket, prior to receiving service.

Right to Request Confidential Communications. You have the right to request that we communicate with you about dental matters in a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests. It is your responsibility to update your contact information with Fenton Family Dentistry if changes are necessary.

OTHER USES OF HEALTH INFORMATION:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose your health information, you may cancel that permission in writing at any time. If you cancel your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Effective February 1, 2014

OUR RESPONSIBILITIES

- Fenton Family Dentistry is required by law to maintain the privacy and security of your health information.
- If there is a breach that compromises the privacy or security of your health information, Fenton Family Dentistry will notify you as required.
- Fenton Family Dentistry is required to follow the duties and privacy practices described in this notice and to provide a copy to you.
- Fenton Family Dentistry will not use or share your health information other than as described in this notice unless we obtain your authorization in writing. For example, we must obtain your authorization in writing to share your health information for purposes of marketing or sale of your information

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we received in the future. The current notice will be posted in the entry with the effective date in the upper right corner. A copy will always be given to you upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Fenton Family Dentistry or with the U.S. Department of Health and Human Service Office for Civil Rights. You will not be penalized for filing a complaint.

- U.S. Department of Health and Human Service Office for Civil Rights by letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. Phone 1-877-696-6775. Online: www. Hhs.gov/ocr/privacy/hippa/complaints/.
- To file a complaint with Fenton Family Dentistry, you must submit your complaint in writing to: Fenton Family Dentistry, 17197 Silver Parkway, Fenton, MI 48430. If you wish to discuss your complaint, you may call our office at (810) 750-3600

Fenton Family Dentistry respects your privacy. Please notify our office if you have any questions or concerns.

Name (Print):	Date:
Signature	