Keels Family and Cosmetic Dentistry
Robert L. Keels, D.M.D.

Welcome to our Family Practice. We consider this a privilege and honor to allow us to care for your dental needs. Our staff is committed to serve you in the most professional manner. To insure that your health is safe guarded to the utmost, we ask that you complete the following questionnaire as accurately as possible. Rest assured this information is held in strict medical confidence.

PATIENT INFORMATION

Date / /

S.S. #	- -
Gender	Male Female
Birth Date	

Name _____ (Last) _____ (First) _____ (Middle)

Street Address _____

City _____ ST _____ Zip _____

E-mail Address _____ Home Phone _____ **Cell Phone or Pager** _____

Employer _____ Work Phone _____

Driver's License# _____ If patient is a minor, give parent's or guardian's name _____

Emergency contact person (other than spouse): _____ Relationship _____

Address: _____ Phone number _____

Whom may we thank for referring you to our office? _____

SPOUSE INFORMATION

Spouse's Name _____ (Last) _____ (First) _____ (Middle)

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ D.O.B. _____

Social Security # _____ Employer _____

RESPONSIBLE PARTY INFORMATION

Name _____ (Last) _____ (First) _____ (Middle) _____ (Marital Status)

Social Security # _____ D.O.B. _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ No. Years Employed ____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance	Secondary Dental Insurance
Insured Name _____	Insured Name _____
Date of Birth _____	Date of Birth _____
Insured Social Security # _____	Insured Social Security # _____
Insured Employer _____	Insured Employer _____
Relationship to patient _____	Relationship to patient _____

If there were a safe and inexpensive way to brighten your smile, would you be interested? YES NO

(PLEASE COMPLETE REVERSE SIDE)

PATTERSON# 200196850

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

DENTAL HISTORY

Do you have a specific dental problem? Describe _____

Do you have dental examinations on a routine basis? Last visit? _____

Do you ever have clicking or discomfort in the jaw joints (TMJ)? Discuss _____

Name of previous dentist (optional) _____

MEDICAL HISTORY

Are you under a physician's care now? Doctor's name? Yes No _____

Have you ever been hospitalized or had a major operation? Yes No _____

Have you ever had a serious head or neck injury? Yes No _____

Are you taking any medications, pills, or drugs? Yes No

List Medications: _____

_____

Are you on a special diet? Yes No Do you use any tobacco products? Yes No

Do you use controlled substances? Yes No

Do you take or have you ever taken the following drugs either orally or IV? *(Please Circle)*

Bisphosphonate Therapy:

Oral Medications	IV Medications
Alendronate (Fosamax)	**Editronate (Didrone)**
Ibandronate (Boniva)	**Pamidronate (Aredia)**
Risedronate (Actonel)	**Zonledronic Acid (Zometa)**
Tiludronate (Skelid)	**Reclast**
Etidronate (Didrone)	

WOMEN Are you: ☐ **Pregnant/Trying to get pregnant?** ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? Do you have any allergies? Please list: _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Please CIRCLE if you have had any of the following:

AIDS / HIV Positive	Chest Pain	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores / Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack / Failure	Low Blood Pressure	Spine Bifida
Arthritis / Gout	Diabetes	**Heart Murmur***	Lung Disease	Stomach / Intestinal Disease
Artificial Heart Valve*	Drug Addiction	**Heart Pace Maker***	**Mitral Valve Prolapse***	Stroke
Artificial Joint*	Easily Winded	Heart Trouble / Disease	Osteoporosis	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Pain in Jaw Joints	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Parathyroid Disease	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Psychiatric Care	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Radiation Treatments	Tumors or Growths
Bruise Easily	Fainting Spells / Dizziness	High Blood Pressure	Recent Weight Loss	Ulcers
Cancer	Frequent Cough	Hives or Rash	Renal Dialysis	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	**Rheumatic Fever***	Yellow Jaundice
			Rheumatism	

Have you ever had any serious illness not listed above? Yes No N/A

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parent or Guardian Date

Dentist's Comments:

Blood Pressure	Date	Blood Pressure	Date	Blood Pressure	Date
Dentist's Signature	Date	Dentist's Signature	Date	Dentist's Signature	Date

KEELS FAMILY & COSMETIC DENTISTRY

Financial Policy

We at KEELS FAMILY & COSMETIC DENTISTRY are pleased you chose us to facilitate and care for your dental health needs. As in the past, we require that payments are made at the time of service. For those patients who have financial assistance from insurance, the co-payment is due at this time.

We accept MasterCard, Visa, American Express, Discover and Care Credit, as well as cash or personal checks. In a few instances we are able to offer financial arrangements. We'll be happy to discuss these options with you if the situation applies.

Emergency Patients: For emergency patients, who are not a patient of record, we will file any insurance claims, as long as we can verify your benefits. If we are unable to verify these benefits, we will require payment in full.

Minors with two separated or divorced parents: When two parents are each responsible for one half of the cost of the children's dental care the parent who brings in the child is responsible for paying the co-payment or full fee. They will also be responsible for collection payment from the other parent.

NSF/Returned Checks: There is a $25.00 fee for processing a returned or NSF check. We reserve the right to reject check payments once a returned or NSF check occurs.

Short Notice Cancellations, Broken Appointments or Disconnected Numbers: Each appointment is a reserved time for you and only you. Each time you do not keep your appointment, other patients who do keep their appoint are penalized. Although we do not like to charge for broken appointments, no-show or short notice cancellations, we do reserve the right to refuse to schedule more appointments unless paid in full before service is commenced and/or charge a $25.00 fee. Also, if the phone number we have on file for you is disconnected leaving us no alternative number to reach you by, we will cancel your appointment and reserve the right to not reappoint your appointment.

Deposits: Many times a deposit is required. This varies by length of appointment or complexity of procedure you require. We will notify you if a deposit is needed.

I, _____, have read and understand the financial policies of KEELS FAMILY & COSMETIC DENTISTRY. I understand that I am ultimately responsible for all fees incurred for my dental treatment. (This agreement will apply to any and all accounts in which I am the responsible party. A copy will be placed in those charts as well as my own).

I also understand that since insurance plans are payment assistance plans, they are not designed to cover the entire cost of treatment. I understand that my dental insurance carrier may pay less than the bill for services. If the insurance claim(s) is not paid in 60 days, the balance will become my responsibility. By signing this form, I have authorized assignment benefits directly to the practice.

Most insurance companies are now "deciding" which type of restorative filling the patient should receive, regardless of the clinical indication. While this office does everything possible to maximize the insurance benefits, I am aware that KEELS FAMILY & COSMETIC DENTISTRY will diagnose the type of restorative filling the tis needed due to their Standard of Care, not what the insurance company decides. This will mean for some patients, based on the insurance company's benefit plan, composite resin (tooth colored) fillings on posterior teeth will only be reimbursed at the amalgam (metal) filling rate, with the remainder of the fee due from the patient.

I am also aware that the office reserves the right to charge 1.5% interest on any balance over 90 days old, as well as any and all additional charges that might occur if the account is turned over for collection and/or attorney services are required.

Signed _____ Date _____

Keels Family & Cosmetic Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

** You may refuse to sign This Acknowledgment **

I_____have received a copy of Keels Family & Cosmetic Dentistry, Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgment

☐ an emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____
_____
_____
_____

Keels Family & Cosmetic Dentistry

Consent For Use and Disclosure of Health Information

Name: _____

Address: _____

Telephone:_____ Social Security Number_____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You man obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time

Signature

I _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature_____Date_____

If a personal representative on behalf of the patient signs this consent, complete the following
Personal Representative's Name:_____
Relationship to Patient:_____

Revocation of Consent

I revoke my Consent to your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____

INCLUDE COMPLETED CONSENT IN THE PATIENTS CHART

Keels Family & Cosmetic Dentistry, LLC
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.

Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

Keels Family & Cosmetic Dentistry, LLC makes every effort to ensure your health information is private. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD

- Treatment: We use medical information about you to provide, coordinate and manage your treatment or services. An example of this would include teeth cleaning services. Various units may share information about you to coordinate your needs such as lab work and prescriptions. Your record may be sent to a doctor to whom you have been referred. You may plan for a friend or relative to pick you up after a procedure. A doctor or employee may believe it is in your best interest to tell your friend or relative what drug you must take that night and what will speed your recovery at home.
- Payment: We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company or a third party. We also may call your dental insurance for pre-approval of a service. We may give dental plan details about your treatment in order for reimbursement to us or you. If someone else is responsible for your payment, we will contact that person.
- Health Care Operations: We may use and release your record to support our business functions (for example, administrative, legal, financial activities). These uses and disclosures are imperative to operate the practice, support treatment and payment, and help patients receive the highest degree of excellence in dentistry. Activities may include measuring quality, reviewing employee performance and training.

  Here is how your dental record may be used for business operations:

  - We may call to remind you about or confirm an appointment, give you information regarding treatment alternatives or other health related benefits and services that

may be of interest to you.

- We may use health information to review our treatment and services.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and 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 with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to reasonable requests to receive confidential communications 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, however, not required 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 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 a paper copy of this notice from us upon request.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

❖ Business Associates

- Business associates of Keels Family & Cosmetic Dentistry, LLC provide some services related to business operations. We have a written contract that requires associates to protect your record in the course of performing their job. Ex: Attorneys, Cleaning services.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

❖ Emergencies: We may use or release your health information during emergencies.

❖ Communication Barriers: We may use or release your health information if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release such information.

❖ Workers' Compensation: We may release information about you to comply with workers' compensation laws or similar programs.

❖ Legal Proceedings: We may release health information about you for the following reasons: Court or Administrative order, Subpoena or other legal process.

- ❖ • Legal Requirements: We will give out medical information about you when required to do so by federal, state or local law.
- ❖ • Public Health Risks: We may release information about you to local, state or federal public health agencies (such as the Food and Drug Administration and Department of Health and Environmental Control) for reasons such as:
    - To prevent or control disease, injury or disability
    - To report adverse events, such as drug reactions
    - To notify a person who may have been exposed to a disease
    - To alert a government agent if we believe a patient is the victim of abuse, neglect or domestic violence.
- ❖ Military, Veterans and National Security: If you are a member of the armed forces, we may release information about you as required by military authorities.
- ❖ Law Enforcement: We may release your health information to a law enforcement official: In response to a court order, subpoena, warrant summons or similar legal process. In response to criminal conduct at this facility. In an emergency to report a crime: the location of a crime or the identity, description or location of the person who committed the crime.
- ❖ Amend: Should you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition as long as the record is kept by Keels Family & Cosmetic Dentistry, LLC. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request to modify your medical record in these cases:
    - The current information is accurate and complete.
    - It is not part of the medical information kept by Keels Family & Cosmetic Dentistry, LLC.
    - The record was not created by us.

If we deny this request you have the right to file a statement of disagreement. We may then prepare a rebuttal and provide you with a copy.

- ❖ Accounting of Disclosures: You have the right to request an "accounting of disclosures", a list of disclosures made about you for reasons other than treatment, payment or business operations.

  Request this list by writing Keels Family & Cosmetic Dentistry, LLC, 600 Squires Pointe Drive, Duncan, SC 29334. Your request may state a period of time, which may not be longer than six years and may not include a date before April 14, 2003.

The first list that you request within a 12 month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

❖ Request Restrictions: You have the right to request that we limit information we use or give out about you for treatment, payment or business operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a treatment that you had to your family.

We are not required to agree to your request! If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information agreement form to Keels Family & Cosmetic Dentistry, LLC, 600 Squires Pointe Drive, Duncan, SC 29334. Please state (1) what you want to limit (2) if you want to limit use, release or both (3) to whom the limits should apply, for example, disclosures to your family.

❖ Request Confidential Communications: You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or only at work.

To request confidential communications, submit a Restriction of Information Agreement form to Keels Family & Cosmetic Dentistry, LLC, 600 Squires Pointe Drive, Duncan SC 29334 We will try to meet all reasonable requests. You must state how or where you wish to be contacted.

❖ Paper Copy of This Notice: You have a right to a paper copy of this Notice at any time. For a copy, call Keels Family & Cosmetic Dentistry, LLC, 600 Squires Pointe Drive, Duncan SC 29334 at 864-661-6365 or request a copy by coming in.

❖ Complaints: Should you believe that your privacy has been violated, you may file a complaint with Keels Family & Cosmetic Dentistry, LLC or with the Secretary of the Department of Health and Human Services. To file a complaint, call the Practice Administrator of Keels Family & Cosmetic Dentistry, LLC at 864-661-6365 or contact the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201.

❖ Other Uses: Other uses and disclosures of medical information not covered by this Notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. Note: We cannot take back disclosures already made with your consent.