Eggert Family Dentistry

www.eggertfamilydentistry.com

Suite 120 700 Village Center Drive

North Oaks, MN 55127 651-482-8412

Elizabeth C. Eggert DDS • Jeffrey M. Eggert DDS

WELCOME TO OUR OFFICE!

Patient Registration

Full Name Mr. Mrs. Ms. Rev. Dr.			Today's Date
			Preferred Name
Date of Birth	Social Security Number*		Referred By
Address			
City	State		Zip Code
Home Phone	Cell Phone		Work Phone
E-mail		Preferred contact:	❑Home ❑Work ❑Cell ❑E-mail
Employer			Occupation
Spouse/Partner	Employer		Cell Phone
Additional Emergency Contact and Phone			

Responsible Party and Dental Insurance Information

Please complete the following with insurance information and/or if someone other than the patient is responsible for this account

Name	Relationship to Patient	Home Phone
Address		Cell Phone
City	State/Zip Code	Work Phone
Employer	Social Security Number*	Date of Birth
Primary Dental Insurance	Subscriber ID	Group ID
Secondary Policy Holder	Relationship to Patient	Date of Birth
Secondary Dental Insurance	Subscriber ID	Group ID
Employer	Social Security Number*	Date of Birth

*Please note, Social Security Numbers are needed for our records unless the account will be paid in full immediately at each visit.

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FINANCIAL PRACTICES

Patient Name _____

We are so excited you have chosen Eggert Family Dentistry. We are committed to providing exceptional service and high quality dentistry for you and your entire family. We know you depend on us to explain all dental procedures and associated fees clearly before we begin treatment. We are dedicated to you and we want you to have a pleasant and comfortable experience with us, therefore we have arranged for flexible and convenient payment options. To keep costs down for you, we are cutting down on the time and expense involved with sending out billing statements. We are happy to save you both time and money every time you visit us.

WE ASK THAT YOU PAY US FOR SERVICES RENDERED THE DAY TREATMENT IS INITIATED BY CHOOSING ONE OF OUR CONVENIENT PAYMENT OPTIONS:

A. Payment on Day of Treatment

- Cash or Check
- Visa, MasterCard, Discover, or American Express Credit Cards or Debit Cards
  - For patients with anticipated insurance benefits, we will accept assignment of benefits, however, we will be collecting your estimated portion of the fee on this day.
  - For treatment plans under $5000, we are pleased to offer a 5% courtesy adjustment (10% for those 65 years and older) for payment in full. For treatment plans over $5000, the courtesy adjustment applies with 10 day pre-payment in full.

B. No and Low Interest Payment Plans

- We use a third party financing company to handle your billing statements and payment collection. This option must be prior arranged and is pending credit approval.

A NOTE TO OUR PATIENTS WITH DENTAL INSURANCE

- All of our payment options also enable you to use your insurance benefits in our office.
- We are happy to process your insurance claim as a service to you at no charge. Whenever possible, claims will be filed electronically.
- We are here to assist you in understanding the nature of your dental plan and to help you maximize your dental benefits. Please be sure to bring your insurance card and benefit book if you desire this assistance.
- Your insurance plan is based upon a contract between your employer and the insurance company. Any amount a plan reimburses for dental services is determined by how much your employer has paid for the plan.
- If you have questions or concerns regarding the specifics of your dental insurance plan, please contact your employer or insurance company directly, as they have designed your plan. We, unfortunately, have no control over your benefits.
- Please be aware that any estimate our office provides regarding benefits of your plan is made in an effort to inform, but not to imply a guarantee of payment by your dental insurance. You are ultimately responsible for all treatment fees incurred.
- We are willing to wait up to 90 days for payment on your services from your insurance company. After 90 days we will bill you in full for your dental treatment services and we expect full payment at this time. Any money we then receive from your insurance company will be reimbursed to you. Credits on your account are issued once every quarter.

I understand and agree to these financial practices. I understand that I am responsible for all fees incurred in the dental treatment of all the people listed under my account. I understand and agree that there will be an interest charge of 1.5% per month on any past due balance over thirty days. I also understand and agree that if I am in default of this agreement, I will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by a collection agency. If I have dental insurance, I agree to have Eggert Family Dentistry as the beneficiary of my insurance dollars. I understand that missed or cancelled appointments may incur a fee and I agree to pay those fees.

Signature _____ Date _____

We are proud that our fees reflect the time Dr. Elizabeth and Dr. Jeff spend with each patient.
Our mission remains to provide “dentistry for a lifetime of smiles.”

DENTAL HISTORY

Patient Name _____

What is the reason for your visit today? _____

Do you have any special requests or concerns? _____

Previous dentist's name _____ Phone number _____

Date of last dental exam _____ Date of last dental x-rays _____

How often do you brush? _____ floss? _____

MY DENTAL HEALTH IS ❑Excellent ❑Good ❑Fair ❑Poor

Please check (✓) one box on each line:
❑My mouth is very comfortable ❑My mouth is moderately comfortable ❑My mouth is uncomfortable
❑My smile is excellent ❑I would like to change my smile ❑I am unconcerned about my smile
❑I will do whatever I must to keep my teeth ❑I want to keep my teeth but only within a certain budget of time and money
❑I've done all dentistry recommended to me ❑I've *not* done dentistry recommended ❑No recommendations

Please check (✓) if you have had problems with the following:

❑ Bad breath	❑ Sensitivity to hot or cold
❑ Bleeding gums	❑ Sores or growths in your mouth
❑ Periodontal treatment	❑ Pain in jaw joints
❑ Food collecting between teeth	❑ Clenching of teeth
❑ Loose or broken fillings	❑ Grinding of teeth or excessive wear

Have you ever had periodontal treatment? Yes No Have you ever had orthodontic treatment? Yes No

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We take a keen interest in all of our patients; to help us understand you a little better, please answer the following:

Why did you select our dental office?

Why did you leave your previous dental office?

What kinds of dental treatment have you done in the past?

Have you ever had a negative experience in a dental office or are you worried or apprehensive about dental care? Explain…

What changes would you make in the appearance of your teeth if we could easily change anything?

What do you look for in a dentist and her team?

Is there anything that would stand in the way of you getting the proper dentistry you need?

Do you have any timelines for completion of your dentistry (i.e., moving, insurance or job changes, weddings, graduations, other?)

Please tell us about your family, hobbies, work…

MEDICAL HISTORY

Patient Name _____

Although dental personnel primarily treat the area in and around the 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:

Describe your physical health ❑Excellent ❑Good ❑Fair ❑Poor Last Physical _____

Physician's Name _____ Phone Number _____

Have you had any surgeries? Yes No Please explain _____

Please list all prescribed and over-the-counter medications or supplements you take _____

_____

Do you consider yourself under an abnormally high amount of stress Yes No Do you sleep well? Yes No

Do you exercise regularly? Yes No Have you had nutritional deficiencies? Yes No

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height: ☐
		For Office Use Only	
		BP ☐ Heart Rate: ☐	Weight: ☐

Y	N	Conditions
☐	☐	Artificial Heart Valve
☐	☐	Congenital Heart Defect
☐	☐	Heart Murmur With Regurgitation
☐	☐	Mitral Valve Prolapse
☐	☐	Angina Pectoris
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Pace Maker
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	High Cholesterol
☐	☐	Congestive Heart Failure
☐	☐	Stroke
☐	☐	Artifical Joints
☐	☐	Arthritis, Type _____
☐	☐	HIV+/AIDS
☐	☐	Hepatitis, Type _____
☐	☐	Tuberculosis
☐	☐	Cold Sores/Herpes
☐	☐	Blood Transfusion
☐	☐	STD, Type _____
☐	☐	Shingles

Y	N	Conditions
☐	☐	Asthma
☐	☐	Difficulty Breathing
☐	☐	Emphysema
☐	☐	Diabetes, Type _____
☐	☐	Hypoglycemia
☐	☐	Allergies, Type, Rxn _____
☐	☐	Hay Fever
☐	☐	Cancer, Type _____
☐	☐	Tumors Or Growths
☐	☐	Chemotherapy
☐	☐	Radiation Therapy
☐	☐	Drug/Alcohol Dependency
☐	☐	Psychiatric Care
☐	☐	Depression
☐	☐	Anxiety
☐	☐	ADHD
☐	☐	Alzheimer's Disease
☐	☐	Dementia
☐	☐	Epilepsy
☐	☐	Seizures
☐	☐	Abnormal/Excessive Bleeding
☐	☐	Blood Disease, Type _____

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Frequent Cough
☐	☐	Acid Reflux
☐	☐	Any Surgeries?
☐	☐	Hospitalized For Any Reason
☐	☐	Systemic Disease, See Below

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Please specify (✓) type(s) of systemic disease(s):

❑Heart Disease ❑Kidney Disease/Problems ❑Liver Disease/Problems ❑Parathyroid Disease
❑Lung Disease ❑Renal Dialysis ❑Yellow Jaundice ❑Hypothyroidism
❑Anemia ❑Stomach Disease ❑Sinus Troubles ❑Hyperthyroidism
❑Sickle Cell Disease ❑Intestinal Disease ❑Tonsillitis ❑Multiple Sclerosis
❑Spina Bifida ❑Ulcers ❑Other _____

Please check (✓) if you have had problems with the following

❑Frequent Headaches ❑Ear Pain ❑Jaw Pain ❑Throat Pain
❑Neck Aches ❑Hearing Changes ❑Jaw Noises ❑Dizziness
❑Back Pain ❑Ear/Sinus Congestion ❑Jaw Locking ❑Fatigue
❑Shoulder Pain ❑Ear/Sinus Pain ❑Difficulty Eating ❑Eye Pain
❑Swelling ❑Ringing Ears ❑Difficulty Sleeping ❑Visual Symptoms
❑Muscle Spasms ❑Other _____

The above information in my dental and medical histories is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions I may have made in the completion of this form.

Date _____ Signature _____

(Parent or Guardian if under age 18)

Eggert Family Dentistry

Elizabeth C. Eggert DDS and Jeffrey M. Eggert DDS

Acknowledgement of Receipt of Notice of Privacy Practices and Consent for Use and Disclosure of Health Information

To the Patient – Please read the following statement carefully

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

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether or not 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 other important matters about your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent.

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. These changes may apply to any of your protected health information that we maintain.

You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

Elizabeth Eggert
Telephone: 651-482-8412 Fax: 651-482-8376
700 Village Center Drive; Suite 120
North Oaks, MN 55127

Consent Does Not Expire after One Year: By signing the Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted within connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we many decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

SIGNATURE

I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. 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. I acknowledge Eggert Family Dentistry as the keeper of my dental records and give them permission for that duty.

_____ _____

Signature Date

Name of Patient, Please Print _____ Telephone _____

Address _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name _____ Relationship _____

(Note: a parent is considered a Personal Representative for a minor under the HIPPA Privacy Regulations.)

For Phone, Text and Email Communications

By checking the boxes below, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. You may choose multiple forms of communication. You must choose at least one in order for us to be able to treat you. The dental practice may:

□ **Call me** □ **Text me** □ **Email me**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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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

In the event that Minnesota State Regulations pertaining to privacy are stricter than Federal Regulations, this Practice will follow the Minnesota State Regulations. If you have any questions about this notice, please contact our Privacy Officer.

We are required by law to maintain the privacy of protected health information and to tell you of our legal duties. Disclosures of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. We use and disclose your information for the purposes of treatment, payment and healthcare operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Unless you give us an additional written authorization, we cannot use or disclose your health information for any reason except as described in this Notice. You may request a copy of our Notice at any time. 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. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website; or by calling the office and requesting that a revised copy be sent to you in the mail; or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract (Business Associate Agreement) that contains terms that will protect the privacy of your protected health information. Effective February 17, 2010, our Business Associate Agreements have been amended to provide that all of the HIPAA security administrative safeguards, physical safeguards, technical safeguards and security policies, procedures, and documentation requirements apply directly to the business associate.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use you health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications to third parties without written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
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 a correctional institution or a law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.
Telephone, Text, Email, and Mail Communications: Upon receiving your consent, Eggert Family Dentistry or its service provider may contact you to provide health care information such as appointment reminders about treatment, payment, and insurance, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. We may charge you a fee for each page and fee for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other that treatment, payment or healthcare operations as described in the Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. 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 these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.
You have the right to restrict information given to your third party payer if you fully pay for the services out of your pocket.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
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.
Security Breach: Effective September 23, 2009, we are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notification requirements under this section only apply if the breach poses a significant risk for financial, reputational, or other harm to you. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Not every impermissible use or disclosure of protected health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to you as a result of impermissible activity. For example, if your protected health information was inappropriately shared with a billing clerk and she understood her confidentiality obligations, you would not need to be notified of the breach. If we inadvertently disclosed that you received services at our facility, without more specifics, this also may not be a reportable breach because it may not have been a significant risk of financial or reputational harm. The key to determining potential harm is whether sufficient information was released that would allow identity theft or harm you because of the likelihood of sharing sensitive health data.
Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

COMPLAINTS
If you are concerned that we may have violated your privacy rights, or 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 may also 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 U.S. Department of Health and Human Services.

Privacy Officer: Elizabeth Eggert
Contact Officer: Elizabeth Eggert
Telephone: 651-482-8412
Fax: 651-482-8376
Address: 700 Village Center Drive, Suite 120, North Oaks, MN 55127
Website: www.eggertfamilydentistry.com

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Elizabeth C. Eggert DDS • Jeffrey M. Eggert DDS

Patient Request for Records Release

Date _____

I hereby authorize and request that my dental or medical (circle one) records be released to
Eggert Family Dentistry, PA
at the following email address: info@eggertfamilydentistry.com

This includes any and all records and information, including, but not limited to dental radiographs, dental chart notes, dental and medical histories, and diagnostic models. If medical records are requested, information regarding which records will be included on a medical consultation request form. If necessary, additional information will be written below.

Patient Name _____

Signature _____

Parent or Guardian Signature if Under 18 _____