

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

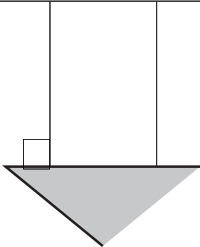
IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

DATE		1	
LAST NAME	FIRST	M.I.	
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE		
MARRIED		DIVORCED	WIDOWED
SOCIAL SECURITY NO.			
DATE			
LAST NAME	FIRST	M.I.	
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME:	RELATIONSHIP:	
<b>YOU WERE REFERRED TO US BY</b>		
<b>YOUR FORMER ADDRESS</b>		
CITY	STATE	ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) \_\_\_\_\_'s dental needs,
2. Upon such diagnosis, I authorize doctor 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. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. 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 service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1 /2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature

Date \_\_\_\_\_ Witness \_\_\_\_\_

Parent/Responsible Party's Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient Name _____
Patient Account No. _____

# DENTAL HISTORY

Medical Alert _____
---------------------

*Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.*

What is the reason for your visit today? \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Last Dental Cleaning \_\_\_\_\_ Last Full Mouth X-rays \_\_\_\_\_

What was done at your last dental visit? \_\_\_\_\_

Previous Dentist's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How often do you have dental examinations? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Have you ever used or are currently using topical fluoride? Yes No

What other dental aids do you use? (Interplak, toothpick, etc.) \_\_\_\_\_

Do you have any dental problems now? Yes No If yes, please describe: \_\_\_\_\_

**Are any of your teeth sensitive to:**

- Hot or cold? ..... Yes No
- Sweets? ..... Yes No
- Biting or Chewing? ..... Yes No
- Have you noticed any mouth odors or bad tastes? ..... Yes No
- Do you frequently get cold sores, blisters or any other oral lesions? ..... Yes No
- Do your gums bleed or hurt? ..... Yes No
- Have your parents experienced gum disease or tooth loss? ..... Yes No
- Have you noticed any loose teeth or change in your bite? ..... Yes No
- Does food tend to become caught in between your teeth? ..... Yes No
- If yes, where \_\_\_\_\_

**Do you:**

- Clench or grind your teeth while awake or asleep? ..... Yes No
- Bite your lips or cheeks regularly? ..... Yes No
- Hold foreign objects with your teeth? (pencils, pipe, etc.) ..... Yes No
- Mouth breathe while awake or asleep? ..... Yes No
- Have tired jaws, especially in the morning? ..... Yes No
- Snore or have any other sleeping disorders? ..... Yes No
- Smoke/chew tobacco or use other tobacco products? ..... Yes No

**Have you ever had:**

- Orthodontic treatment? ..... Yes No
- Oral Surgery? ..... Yes No
- Periodontal treatment? ..... Yes No
- Your teeth ground or the bite adjusted? ..... Yes No
- A bite plate or mouth guard? ..... Yes No
- A serious injury to the mouth or head? ..... Yes No
- Please describe, including cause \_\_\_\_\_

**Have you experienced:**

- Clicking or popping of the jaw? ..... Yes No
- Pain? (joint, ear, side of face) ..... Yes No
- Difficulty in opening or closing the mouth? ..... Yes No
- Difficulty in chewing on either side of the mouth? ..... Yes No
- Headaches, neckaches or shoulder aches? ..... Yes No
- Sore muscles (neck, shoulders)? ..... Yes No
- .....

**Are you satisfied with your teeth's appearance? Yes No**

- Would you like to replace your silver fillings? ..... Yes No
- Would you like to keep all of your teeth all of your life? .... Yes No

Do you feel nervous about having dental treatment? ..... Yes No  
 Please describe \_\_\_\_\_

Have you ever had an upsetting dental experience? ..... Yes No  
 Please describe \_\_\_\_\_

Have you ever been told to take a pre-medication prior to dental treatment? ..... Yes No

Is there anything else about having dental treatment that you would like us to know? ..... Yes No

If yes, please describe \_\_\_\_\_  
 \_\_\_\_\_

(Please complete other side)

# MEDICAL HISTORY

Patient Name _____	
Patient Account No. _____	Medical Alert _____

1. Physician's Name \_\_\_\_\_ Phone (       ) \_\_\_\_\_  
 Have you had any medical care within the past two years? ..... Yes    No  
 Describe \_\_\_\_\_
  
  2. Have you taken any medication or drugs during the past two years? ..... Yes    No  
 If yes, please list name and dosage \_\_\_\_\_
  3. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ..... Yes    No  
 If yes, please list name and dosage \_\_\_\_\_
  4. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates? ..... Yes    No  
 If yes, please list name and dosage \_\_\_\_\_
  5. Are you aware of having an allergic (or **adverse**) reaction to any substance or medication? ..... Yes    No  
 If yes, please specify \_\_\_\_\_
  6. Have you been a patient in the hospital during the past five years? ..... Yes    No
  7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
- |  |     |    |                               |     |    |                                  |     |    |
|--|-----|----|-------------------------------|-----|----|----------------------------------|-----|----|
| Heart (Surgery, Disease, Attack)...      | Yes | No | Ulcers .....                  | Yes | No | Hepatitis A B C (circle) ...     | Yes | No |
| Chest Pain .....                         | Yes | No | Diabetes .....                | Yes | No | Venereal Disease .....           | Yes | No |
| Congenital Heart Disease .....           | Yes | No | Thyroid Problems .....        | Yes | No | A.I.D.S./H.I.V. Positive .....   | Yes | No |
| Heart Murmur .....                       | Yes | No | Glaucoma .....                | Yes | No | Cold Sores/Fever Blisters .....  | Yes | No |
| High/Low Blood Pressure .....            | Yes | No | Contact lenses .....          | Yes | No | Blood Transfusion .....          | Yes | No |
| Mitral Valve Prolapse .....              | Yes | No | Emphysema .....               | Yes | No | Hemophilia .....                 | Yes | No |
| Artificial Heart Valve/Pacemaker .....   | Yes | No | Chronic Cough .....           | Yes | No | Sickle Cell Disease .....        | Yes | No |
| Rheumatic Fever .....                    | Yes | No | Tuberculosis .....            | Yes | No | Bruise Easily .....              | Yes | No |
| Arthritis/Rheumatism .....               | Yes | No | Asthma .....                  | Yes | No | Liver Disease/Yellow Jaundice .. | Yes | No |
| Cortisone Medicine .....                 | Yes | No | Hay Fever/Allergy/Hives ..... | Yes | No | Neurological Disorders .....     | Yes | No |
| Swollen Ankles .....                     | Yes | No | Latex Sensitivity .....       | Yes | No | Epilepsy or Seizures .....       | Yes | No |
| Stroke .....                             | Yes | No | Sinus Trouble .....           | Yes | No | Fainting or Dizzy Spells .....   | Yes | No |
| Diet (Special/Restricted) .....          | Yes | No | Radiation Therapy .....       | Yes | No | Nervous/Anxious .....            | Yes | No |
| Artificial Joints (hip, knee, etc.) .... | Yes | No | Chemotherapy .....            | Yes | No | Psychiatric/Psychological Care.. | Yes | No |
| Kidney Trouble .....                     | Yes | No | Tumors .....                  | Yes | No | Cancer .....                     | Yes | No |
- 
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes    No
  9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes    No  
 If yes, please list: \_\_\_\_\_
  10. **Women:** Are you pregnant or think you could be pregnant?    Yes    \_\_\_\_\_ Months    No       **Nursing?**    Yes    No
  11. Do you use birth control prescriptions? ..... Yes    No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## History Review

Dentist Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME \_\_\_\_\_

**PATIENT INTERVIEW**

What is your main concern regarding your teeth (appearance, comfort, health)?

On a scale of 1-10, how would you rate your teeth (ten being the best)?

If you could change anything about your smile, what would it be?

Are you satisfied with the color of your teeth?

Have you ever used any professional or over-the-counter whitening products?

Would you like some information on the latest professional whitening available?

Is there anyone else in your life that you would like to involve in your decisions regarding your dental care?

**SPECIAL NOTE TO NEW PATIENTS:**

A PROFESSIONAL CLEANING PERFORMED BY A DENTAL HYGIENIST OR A DENTIST IS A MEDICAL PROCEDURE, AND MUST BE PRESCRIBED BY A QUALIFIED HEALTH CARE PRACTITIONER. IN SOME CASES, DENTAL CONDITIONS EXIST THAT HAVE TO BE ADDRESSED BEFORE A CLEANING IS POSSIBLE. IN OTHER CASES, A DIFFERENT TYPE OF CLEANING THAN WHAT IS USUALLY PRESCRIBED IS NEEDED FOR THE HEALTH OF THE PATIENT.

BECAUSE OF THIS, LEGALLY AND ETHICALLY, AN EXAMINATION AND X-RAYS AS REQUIRED BY THE DENTIST MUST BE DONE BEFORE ANY TYPE OF CLEANING CAN BE STARTED. AFTER AN EXAM AND X-RAYS HAVE BEEN DONE, THE DOCTOR WILL BE ABLE TO SEE WHETHER OR NOT A CLEANING IS NEEDED AS THE NEXT STEP, OR IF A DIFFERENT PROCEDURE (WHICH MAY INCLUDE A MORE INVOLVED TYPE OF CLEANING) IS REQUIRED.

DR. ELFERVIG AND HIS STAFF ARE COMMITTED TO HELPING THEIR PATIENTS ACHIEVE AND MAINTAIN HEALTHY TEETH AND GUMS FOR THE LONG TERM. THE PROCEDURES WE FOLLOW ARE IN THE INTEREST OF ACHIEVING THIS FOR AS MANY OF OUR PATIENTS AS POSSIBLE.

I have read the above statement, I have been given the opportunity to ask any questions about it, and I understand it.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

## PATIENT APPOINTMENT POLICY

Dear Valued Patient,

**Our purpose is to help our patients keep their teeth and gums healthy for life.**  
**Proper scheduling of appointments is vital to that endeavor. Therefore, we ask for your cooperation regarding the following appointment policy:**

- 1) Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. We try to remind patients by telephone, email, and text prior to their appointment, but please do not depend on this courtesy. If we are unable to reach you, your appointment card will serve as the confirmation of your appointment and implies your obligation to be present. That time has been reserved especially for you. This means no other patient has been scheduled for that particular time slot, and that anyone else wishing to schedule for that time has had to be given a different time for their appointment. We reserve the right to charge for office visits cancelled or broken without 2 business days advance notice (e.g. if your appointment is scheduled for Monday at 3 P.M., and you need to re-schedule, you must call us before the prior Wednesday at 3 P.M.). Exceptions to this policy can be determined only on an individual basis according to the circumstances. The broken appointment charge will depend on the procedure and time reserved. These charges are allowed by your insurance company, but considered as the patient's responsibility to pay.
- 2) In order to ensure that we keep to our schedule, and yours, as much as possible and to minimize patient waiting time, it is necessary to schedule certain procedures for specific times during the day. This allows us to provide you with the excellence in care that you expect and deserve. We know that your time is valuable and that none of our patients want to spend any longer in the dentist's office than they have to. Scheduling specified procedures for specific time slots allows us to be more efficient with your treatment and actually minimizes the time you have to spend at our office.

If you have any questions about the policy; do not hesitate to ask our office staff. **We believe that good communication is the key to excellence in dental care.**

# Mark T. Elfervig, D.D.S., P.A.

## HIPAA Privacy Form

### 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. The privacy of your health information is important to us.

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**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 your health information to obtain payment for services we provide to you.

**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.

**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 your 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**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, but only if you agree that we may do so.

**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 our 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 without your written authorization.

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## HIPAA Privacy Form (Continued)

**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 correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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### **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. If you request copies, we will charge you \$0.\_\_\_\_ for each page, \$\_\_\_\_ per hour 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 a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 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).

**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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**Transferring Medical Records:** Patients have a right to have their medical record transferred to any provider they choose.

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### **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 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.

Contact Officer: Tamra Murtha

Telephone: (941) 795-0144

**Mark T. Elfervig, D.D.S., P.A.**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_