Patient Registration
Designs, P.C.

Riverview Dental

J. Paul Diaz, D.M.D., M.A.G.D.

ID:_____ Chart ID:_____

First Name:_____ Middle Name:_____ Last Name:_____

Preferred Name:_____

Preferred Dentist:_____ Preferred Dental Hygienist:_____

Preferred Pharmacy:_____ Pharmacy Phone Number:_____

Patient Is (circle one): Policy Holder Responsible Party

Responsible Party (if someone other than the patient; leave blank if you are the responsible party)

First Name:_____ Middle Name:_____ Last Name:_____

Date of Birth:_____ Social Security #:_____ Driver's License #:_____

Address:_____ Address 2:_____

City:_____ State:_____ Zip Code:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____ Ext:_____

O Responsible party is also Policy Holder the patient **O** Primary Insurance Holder **O** Secondary Insurance Policy Holder

Patient Information

Date of Birth:_____ Age:___ Social Security #:_____ Driver's License State and #:_____

Address:_____ Address 2:_____

City:_____ State:_____ Zip Code:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____ Ext:_____

Sex (circle one): Male Female Marital Status (circle one): Married Single Divorced Separated Widowed

Employment

Employment Status (circle one): Full Time Part Time Retired Student Status (circle one): Full Time Part Time

Name of Employer:_____ Your Position:_____

Employer Address:_____ City, State, Zip:_____

Medicaid ID:_____ Employer ID:_____ Carrier ID:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured (circle one): Self Spouse Child Other

Insured Social Security #:_____ Insured Date of Birth:_____

Name of Insurance Company:_____

Insurance Company Address:_____ City, State, Zip:_____

Remaining Benefits:_____ Remaining Deductible:_____

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured (circle one): Self Spouse Child Other

Insured Social Security #:_____ Insured Date of Birth:_____

Name of Insurance Company:_____

Insurance Company Address:_____ City, State, Zip:_____

Remaining Benefits:_____ Remaining Deductible:_____

Medical History **Riverview Dental Designs, P.C.**

J. Paul Diaz, D.M.D., M.A.G.D.

Patient Name:_____ Date of Birth:_____

Note: 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 dental care you will receive. Thank you for answering the following questions accurately.

Are you under a physician's care now? ___Yes ___No If yes, please explain:_____

Have you ever been hospitalized or had a major operation? ___Yes ___No explain:_____

Have you ever had a serious head or neck injury? ___Yes ___No explain:_____

Are you taking any medications, pills, or drugs? ___Yes ___No Please list:_____

_____

_____

Do you take, or have you taken, Phen-Fen or Redux? ___Yes ___No

Have you ever taken Fosamax, Boniva, Actonel, Aredia, Zometa or any other drugs containing Bisphosphonates? ___Yes ___No

Please list:_____

___

Are you on a special diet? ___Yes ___No

Do you use tobacco? ___Yes ___No Type (circle): Cigarettes/Cigars/Pipe Chew/Dip E-cigarette/Vape

Do you use controlled substances? ___Yes ___No Please list:_____

Women, are you (circle if any apply): Pregnant/Trying to get pregnant Nursing Taking Oral Contraceptives

<u>Allergies:</u>

Are you allergic to (circle all that apply): Latex Aspirin Penicillin Codeine Acrylic Metal Local Anesthetics Sulfa Drugs

List any others and/or explain reaction to any allergies listed above:_____

Do you have, or have you had, any of the following (please place a small ✓ or X in the corresponding boxes):

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

Have you ever had any serious illness not listed above? ___Yes ___No

explain:_____

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 my medical status.

Signature of Patient, Parent or Guardian:_____
Date:_____

Communication Preferences **Riverview**
Dental Designs, P.C.

J. Paul Diaz, D.M.D., M.A.G.D.

Our office uses automated email and text message reminders to confirm scheduled patient appointments, inform patients when they are due to schedule an appointment, and communicate important information about our practice (i.e. schedule changes due to severe weather, updates or promotions at our office, etc). If we are unable to confirm your scheduled appointment via email or text message, or if you simply prefer, phone calls are made for confirmation of scheduled appointments and to relay important information. ***Great communication is a vital part of any healthy working relationship and aids us in providing the highest standard of service and dental care to our patients.***

We ask that you confirm your appointments using one of the three preferred methods (your choice) offered by our office. We also ask that every attempt be made to keep your originally scheduled appointment date and time. We do understand that unexpected events arise and schedules can change that make it necessary to reschedule an appointment with our office. If this is the case, we ask for ***a direct phone call (voicemail, email, and text message are not preferred) and notice of at least 2 business***

days. This will allow us to schedule another patient to be seen in your place. We take pride in scheduling specific time for each patient to receive the quality care that they deserve, and appreciate your cooperation and consideration in helping make this possible. ***Failure to comply with confirmation and rescheduling policies may result in the need to prepay for appointments***.

I do hereby authorize employees of Riverview Dental Designs, P.C. to communicate with me via phone call, email, and/or text message. I agree to comply with their policies regarding confirming and rescheduling appointments.

_____
_____

Patient/Guardian Signature **Date**

Referral Source (how did you find our office):
_____

List other family members who are patients here:
_____

_____
_____

Preferred method of communication (circle one): Email Text Message Phone Call

Preferred email address: _____

Preferred phone number: _____ home cell work (circle one)

Most likely to use (circle one): Google Facebook Yelp

<u>Emergency Contact</u>

Name of Contact: _____ Relationship to Patient: _____

Cell Phone: _____ Work/Home Phone: _____

FINANCIAL OPTIONS **RIVERVIEW**

DENTAL DESIGNS, P.C.

J. Paul Diaz, D.M.D., M.A.G.D.

Our goal is to provide you with optimal care based on your individual needs. To assist you in receiving this care, we offer several payment options.

Please indicate below the form of payment you choose: *(check one):*

❑ **Payment of my portion at each visit with:** (Circle One) **Cash** **Check**

❑ **Payment of my portion at each visit and my balance, if any, after insurance payment with:** (Circle One)

Visa **MasterCard** **American Express** **Discover**

_____ _____ _____ / _____

Card #
Expiration Date

❑ **CareCredit® Payment Plan** ∗Subject to credit approval. See patient brochure for information.

Care Credit ID:_____

I hereby authorize payment directly to Riverview Dental Designs, PC of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dentists of Riverview Dental Designs, PC to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Riverview Dental Designs, PC to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

SERVICE CHARGE: If I do not pay the entire new balance within 60 days of the appointment date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month, which is an annual percentage rate of 18%, applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. The person signing below hereby agrees to waive any exemptions that he or she may be entitled to claim under the Laws or the Constitution of the State of Alabama.

There will be a $30.00 charge for all returned checks.

_____ _____

Signature of Patient / Responsible Party **Date**

Thank you for choosing us for your dental needs.

If you have questions about your suggested treatment plan or the available payment options, please ask us. We are here to help you!

NOTICE OF PRIVACY PRACTICES

Riverview Dental Designs, P.C.

J. Paul Diaz, D.M.D., M.A.G.D.

805 Rice Mine Road North

Tuscaloosa, Alabama 35406

(205) 345-3400

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information 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 we describe in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until replaced. 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.

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 for 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.

To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To an organ procurement organization;
- To avert a serious threat or health safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

Your Authorization: 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 our 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.

PATIENT RIGHTS

Access: You have the right to view or obtain 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 practically do so. You must make a request in writing to obtain access to your health information. You may request copies by sending a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 or your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation or 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 (must be in writing). 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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you believe that:

1. We may have violated your privacy rights,
2. We made a decision about access to your health information incorrectly
3. Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
4. We should communicate with you by alternative means or at alternative locations.

You may contact us using the information listed below. 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 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:

Monica Watt

805 Rice Mine Road North

Tuscaloosa, AL 35406

Phone: (205) 345-3400

Fax: (205) 345-6555

Riverview Dental Designs, P.C.

J. Paul Diaz, D.M.D., M.A.G.D.

805 Rice Mine Road North
Telephone (205) 345-3400

Tuscaloosa, AL 35406
Fax: (205) 345-6555

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

_____

You May Refuse to Sign This Acknowledgement

I, (Please Print Name) _____, have received a copy of this Office's Notice of Privacy Practices.

_____
_____

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) _____

_____
_____