PATIENT REGISTRATION

ID: _____ Chart ID: _____

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

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

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

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg: _____

Section 3

See Notes! _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ Rem. Deduct: _____

SmileArts Dental Studio

Eaglesoft Medical History(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

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

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized, had a major operation or had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Have you ever been asked to pre-med before a dental procedure?	◯ Yes ◯ No	If yes

Women: Are you...

Pregnant	◯ Yes ◯ No
Trying to get pregnant	◯ Yes ◯ No
Nursing	◯ Yes ◯ No

Are you allergic to any of the following?

Aspirin	◯ Yes ◯ No
Penicillin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No
Acrylic	◯ Yes ◯ No
Metal	◯ Yes ◯ No
Latex	◯ Yes ◯ No
Local Anesthetics	◯ Yes ◯ No

Other allergies? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Epilepsy or Seizure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Swelling of Limbs	◯ Yes ◯ No	Arthritis/Rheumatic	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Fainting Spells/Dizzines	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Heart Murmur/Defect	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Hepatitis A, B or C	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Venereal Disease	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No				

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

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:

X Date:_____

Aaron T. Cohenour, DDS, PC

Effective Date of Notice: 6/1/2013

HIPAA NOTICE OF PRIVACY PRACTICES ("Notice")

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Dental Practice Covered by this Notice:

This notice describes the privacy practices of Aaron T. Cohenour, DDS PLLC, DBA SmileArts Dental Studio ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "Your" means our patient.

How to Contact Us/Our Information:

Dental Practice Name:	SmileArts Dental Studio
Privacy Official for Dental Practice:	Kristi Davis
Dental Practice Mailing Address:	820 S. Mustang Rd, Yukon, OK 73099
Dental Practice Phone Number:	405-577-2444

Information covered by this Notice:

This notice applies to health information about you that we create or receive that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- Maintain the privacy of your health information
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

Common Reasons for our Use and Disclosure of Patient Health Information:

Treatment-We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
Payment-We may use and disclose your health information to obtain payment from health plans, insurers, and payment providers.
Health Care Operations-We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
Appointment Reminders-We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, email, or text message.
Treatment Alternatives and Health-Related Benefits and Services-We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.
Disclosure to Family Members and Friends-We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

Less Common Reasons for Use and Disclosure of Patient Health Information:

Disclosures Required by Law-We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPPA.
Public Health Activities-We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
Victims of Abuse, Neglect or Domestic Violence-We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect, or domestic violence.
Health Oversight Activities-We may disclose patient health information to a health oversight agency for activities necessary for the government o provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.
Lawsuits and Legal Actions-We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoenas, discovery request, or other lawful process that is nt ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.
Law Enforcement Purposes-We may disclose patient health information to a law enforcement official for law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.
Coroners, Medical Examiners and Funeral Directors-We may disclose patient health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.
Organ, Eye and Tissue Donation-We may use or disclose patient health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.
Research Purposes-We may use or disclose patient health information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.
Serious Threat to Health or Safety-We may use or disclose patient health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.
Specialized Government Functions-We may disclose patient health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President of other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.
Workers' Compensation-We may disclose patient health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in the Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.

Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPPA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

Access-You may request to review or request a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge reasonable fee to cover our cost to provide you with copies of your health information.
Amend-If you believe that your health information if incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe if incorrect or incomplete.
Restrict Use and Disclosure-You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception. If you pay out of pocket in full for service you receive from us and you request that we not submit the claim for this service to your health insurer of health plan for reimbursement, we must honor that request.
Confidential Communications: Alternative Means, Alternative Locations-You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate the communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of the Notice, you need to provide and alternative method of contact or alternative address and indicate how payment for the services will be handled.
Accounting of Disclosures-You have a right to receive and accounting of disclosures of your health information for the six years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPPA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.
Receive a Paper Copy of this Notice-You have the right to a paper copy of this notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

We Have the Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice (including any updates) is at the top of the Notice.

To Make Privacy Complaints

If you have any complaint about your privacy right of how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the top of this Notice. You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Signature _____ Date _____

Printed Name _____ I Authorize you to release info to: _____