

PATIENT REGISTRATION

NAME _____ DATE OF BIRTH ____ / ____ / ____ SS# _____

ADDRESS _____ CITY _____ STATE **MI** ZIP _____

RESPONSIBLE PARTY

NAME _____ DATE OF BIRTH ____ / ____ / ____ SS# _____

ADDRESS _____ CITY _____ STATE **MI** ZIP _____

DRIVERS LICENSE # _____ REFERRED BY: _____

HOME PH# (____) _____ BUSINESS PH# (____) _____ CELL PH# (____) _____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____ CITY _____ STATE **MI** ZIP _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE# (____) _____

DENTAL INSURANCE

Primary

Subscriber (Employee) _____

Birthdate _____

SS# _____

Employed by: _____

Dental Ins Co. _____

Phone: _____

Group/Policy# _____

Secondary

Subscriber (Employee) _____

Birthdate _____

SS# _____

Employed by: _____

Dental Ins Co. _____

Phone: _____

Group/Policy# _____

AUTHORIZATION, RELEASE, AND AGREEMENT

I understand that I am responsible for payment of all services rendered on my behalf and on behalf of my dependent/s. I understand that payment is due at the time of service. I understand that I will be responsible for any fees charged to me for broken appointments or appointments canceled without 48 hours notice.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers/ and or other healthcare practitioners so that a claim for reimbursement can be filed on my behalf.

SIGNATURE OF PATIENT

DATE

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.

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).

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 of recent radiographs, we will fulfill your request free of charge. However, if you require any further chart history or a summary of your dental information, we will charge you \$25.00 for staff time to process this request. Contact us using the information listed at the end of this Notice for a full explanation of this policy.)

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.

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: Susan Hedlund_____

Telephone: (248) 656-2020_____ Fax: (248) 656-2559_____

E-mail: _____

Address: 433 W. University Rochester, Mi, 48307_____

