Knutson Family Dentistry
1714 E. Cherry Street • Vermillion, SD 57069
605.624.6291 • office@knutsonfamilydentistry.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy):	Marital Status:	Social Security #:
		/ /		- -

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Home Address:	City:	State:	ZIP Code:

Employer's Name:	Employer's Phone:	Occupation:
	- -	

Are you a student? Yes No

Best places and times to contact you:	Send appointment reminders via:
	Text Message Email Mail

How did you hear about us? (check all that apply):

Friend or Relative (name): _____

Ad in Mail Street Sign Insurance Company Our Website
Search Engine (Google, etc.) Newspaper Ad Radio Ad TV Ad

Other:

Was our website a factor in your decision to visit our practice? Yes No

Other family members treated by us:	Additional Comments:

Person Responsible for Account

First Name:	Middle Name:	Last Name:	Relationship to Patient:
Date of Birth (mm/dd/yyyy): / /	Social Security #: - -	Are you the Policy Holder for the Patient? Yes No	
Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:
Billing Address:	City:	State:	ZIP Code:
Employer's Name:	Employer's Phone: - -	Occupation:	

Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -
Insured's SSN:	Insurance Company's Address:	City:	State: ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:
Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -
Insured's SSN:	Insurance Company's Address:	City:	State: ZIP Code:

Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:	Phone: - -
Last Dental Visit:		

Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?
Are you interested in regular hygiene cleanings?		

Medical History

Are you under a physician's care now? Yes No	Name:	
Have you ever been hospitalized or had a major operation? Yes No	What for?	
Have you ever had a serious head or neck injury? Yes No		
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		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No	If yes, which ones?	
Are you on a special diet? Yes No		
Do you use Tobacco? Yes No		

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Knutson Family Dentistry to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Knutson Family Dentistry. I permit a copy of this authorization to be used in place of the original. I give Knutson Family Dentistry, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Do you use controlled substances? Yes No

Women: Are you…		
Pregnant/Trying to get pregnant?	Yes	No
Nursing?	Yes	No
Taking Oral Contraceptives?	Yes	No

Are you allergic to any of the following?			
Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Other?			

Do you have, or have you had, any of the following?					
AIDS/HIV Positive	Yes No	Excessive Bleeding	Yes No	Mitral Valve Prolapse	Yes No
Alzheimer's Disease	Yes No	Excessive Thirst	Yes No	Osteoporosis	Yes No
Anaphylaxis	Yes No	Fainting Spells/Dizziness	Yes No	Pain in Jaw Joints	Yes No
Anemia	Yes No	Frequent Cough	Yes No	Parathyroid Disease	Yes No
Angina	Yes No	Frequent Diarrhea	Yes No	Psychiatric Care	Yes No
Arthritis/Gout	Yes No	Frequent Headaches	Yes No	Radiation Treatments	Yes No
Artificial Heart Valve	Yes No	Genital Herpes	Yes No	Recent Weight Loss	Yes No
Artificial Joint	Yes No	Glaucoma	Yes No	Renal Dialysis	Yes No
Asthma	Yes No	Hay Fever	Yes No	Rheumatic Fever	Yes No
Blood Disease	Yes No	Heart Attack/Failure	Yes No	Rheumatism	Yes No
Blood Transfusion	Yes No	Heart Murmur	Yes No	Scarlet Fever	Yes No
Breathing Problems	Yes No	Heart Pacemaker	Yes No	Shingles	Yes No
Bruise Easily	Yes No	Heart Trouble/Disease	Yes No	Sickle Cell Disease	Yes No
Cancer	Yes No	Hemophilia	Yes No	Sinus Trouble	Yes No
Chemotherapy	Yes No	Hepatitis A	Yes No	Spina Bifida	Yes No
Chest Pains	Yes No	Hepatitis B or C	Yes No	Stomach/Intestinal Disease	Yes No
Cold Sores/Fever Blisters	Yes No	Herpes	Yes No	Stroke	Yes No
Congenital Heart Disorder	Yes No	High Blood Pressure	Yes No	Swelling of Limbs	Yes No
Convulsions	Yes No	High Cholesterol	Yes No	Thyroid Disease	Yes No
Cortisone Medicine	Yes No	Hives or Rash	Yes No	Tonsillitis	Yes No
Diabetes	Yes No	Hypoglycemia	Yes No	Tuberculosis	Yes No
Drug Addiction	Yes No	Irregular Heartbeat	Yes No	Tumors or Growths	Yes No
Easily Winded	Yes No	Kidney Problems	Yes No	Ulcers	Yes No
Emphysema	Yes No	Leukemia	Yes No	Venereal Disease	Yes No
Epilepsy or Seizures	Yes No	Liver Disease	Yes No	Yellow Jaundice	Yes No

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill the day of service. I authorize Knutson Family Dentistry to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Knutson Family Dentistry. I permit a copy of this authorization to be used in the place of the original. I give Knutson Family Dentistry, its employees, and/or other agents express prior consent to the contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

All of the above information is correct is the best of my knowledge. 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. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may be release information to you.

Signature	Date (mm/dd/yyyy): / /

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- 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.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all.

Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose

- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures. Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 15, 2015, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.

Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights 200
Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Knutson Family Dentistry to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy):

Methods of Payment

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Cash
Check
Credit Card
CareCredit
Savings Plan
Would you like to discuss our office's financial policy? Yes No

For Office Use Only			
Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.			
Describe your good faith effort to obtain the individual's signature on this form:			
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /