HARRIS & REYNOLDS
FAMILY DENTAL

We are pleased to welcome you into our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial
Address _____ How long at this address?_____
City _____ State _____ ZIP _____ Home Phone _____
Cell Phone _____ Email _____
Sex □ M □ F Age____ Birth date _____ □ Single □ Married □ Widowed □ Separated □ Divorced
Employer _____ Number of Years _____ Occupation _____
Business Phone _____
Whom may we thank for referring you? _____
Notify in case of Emergency _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient) _____
City _____ State _____ ZIP _____ Phone Number _____
Cell Phone _____ Email _____
Employer _____ Occupation _____
Business Phone_____
Insurance Company _____ Phone _____
Group #_____ Subscriber # _____

Additional Insurance

Is patient covered by additional insurance? □ Yes □ No
Subscriber Name _____ Relationship to Patient _____ Birthdate _____
Address (if different from patient) _____ Soc. Sec. # _____
City _____ State _____ ZIP _____ Home Phone _____
Cell Phone _____ Email _____
Subscriber's Employer _____ Business Phone _____
Insurance Company _____ Phone _____
Insurance Email _____
Group #_____ Subscriber # _____

The information that I provided above is accurate. I understand that it is my responsibility to contact my dental insurance company to determine what dental insurance benefits I have available. I also understand that as a courtesy Harris and Reynolds Family Dental will help me file my claims for dental work performed at their office. I understand that any amounts quoted to me by Harris & Reynolds Family dental or by my insurance company is not a guarantee of the exact out-of-pocket expenses. Any amounts not covered by insurance are my financial responsibility. Payment is due when services are rendered.
Signature (Parent/Guardian Signature, if minor) _____

HARRIS & REYNOLDS FAMILY DENTAL

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 dentistry you will receive. Thank you for answering the following questions.

Patient Name: _____

Primary Physician's Name: _____

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 If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list all medications: _____

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 _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other, please explain: _____

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

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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please 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 medical status.

Signature of Patient, Parent or Guardian_____ Date _____

HARRIS & REYNOLDS FAMILY DENTAL

We are pleased to welcome you into our practice. So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.

Patient Name: _____

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_____ City _____State_____ ZIP _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
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? Yes No
(pencils, pipe, pins, nails, fingernails, etc.)
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Snore or have any other sleep 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 your bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, please describe, including cause_____
_____

Have you experienced:
Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of the 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?
Sore muscles (neck, shoulders)?

Are you satisfied with your teeth's appearance? 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
If so, what is your biggest concern?_____ Yes No
_____
Have your ever had an upsetting dental experience? Yes No
If yes, please describe_____
_____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____
_____
_____

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FINANCIAL POLICY

We are committed to providing you and your family with the best possible care. Your clear understanding of our financial policy is important to the success of our relationship with you, and we are pleased to discuss our professional fees with you at anytime. We have prepared the following information to assist you in your planning and provide two copies, one for you to sign and return to our office and one for your records.

For Our Patients With Insurance

We are happy to file the forms necessary to see that you receive the full benefit from your primary insurance coverage; however, we cannot guarantee any estimated coverage. Because your insurance policy is an agreement between you and your insurer, we ask that our patients be directly responsible for all copayments and pay the estimated patient responsibility, (EPR), a the time of service. We remind you that the criteria we use to establish our fees may not necessarily correspond with the criteria used by your insurer. For that reason, you may be responsible for amounts not covered by your policy. If an ALTERNATE treatment or material is substituted by the insurance company for the treatment you receive, you are responsible for the fees exceeding the insurance fee allowance. Although we will do everything possible to see that you receive your maximum benefit, please be aware that we will expect payment in full from you if we have not received insurance payment within 60 days of treatment.

For Our Self-Pay Patients

Payment is expected at the time of service.

Payment Options

We accept payment by Cash, Check, Visa, MasterCard, Discover, American Express and CareCredit. For those patients interested in exploring financing options for major procedures, we will gladly provide you with information on companies who offer such services.

The Financial Policy continues on the backside of this page.

Thank you for reviewing our Financial Policy.
Please contact us with any questions.

MY SIGNATURE BELOW INDICATES MY ACCEPTANCE OF HARRIS & REYNOLDS FAMILY DENTAL'S FINANCIAL POLICIES.

_____ _____

SIGNATURE DATE

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FINANCIAL POLICY (CONT.)

Missed Appointment Fee

The second time a patient does not present on time for an appointment, or cancels with less than 72-hour notice, it is our custom to assess a $50.00 fee. This fee must be paid before another appointment is scheduled. Patients with three missed appointments may be asked to transfer their record to another office. Exceptions will be considered on an individual basis.

Divorce

After a divorce or separation, the patient authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires that other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Finance Charge

A finance charge will be imposed on each item of your account, which has not been paid within **sixty (60) days** of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of and and one-half percent (1 1/2 %) per month or an ANNUAL PERCENTAGE RATE of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1 1/2 %) to the "overdue balance" of your account. The "overdue balance" is calculated by taking the balance owed sixty (60) days ago and subtracting any payment or credits applied to the account during that time.

Past Due Accounts

If your account becomes past due, we will take the necessary steps to collect the balance owed. If we have to refer your account to a collection agency or if the account requires legal action, you agree to pay all the collection costs and legal fees that are incurred. Consideration of reinstatement to active patient status would require payment of balance and all collection costs with the agreement that future changes are paid in full at the time of service.

Returned Checks

In the rare case of a check returned for insufficient funds, we will assess a processing fee of $30.00 on your account and will allow one week for receipt of a money order for the account balance and fee.

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SIGNATURE ON FILE

PATIENT'S NAME _____
Last **First** **Middle Initial**

I hereby authorize payment directly to **HARRIS & REYNOLDS FAMILY DENTAL** of the benefits otherwise payable to me.

_____
Signature (Insured Person)

_____
Date

Signature is valid indefinitely until it is revoked by me.

Harris & Reynolds Family Dental is authorized to provide any insurance company(s), claim administrator(s) and consulting healthcare professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of the coverage of the policy or contract.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

_____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET 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 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 an 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 another dentist or specialist, physician or other healthcare provider providing treatment to you.

Payment: We may use or 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 health care 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, you 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 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 will not use 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 or 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 you health or safety or the health or safety of others.

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NOTICE OF PRIVACY PRACTICES (CONT.)

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 that 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 and $ N/A 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 you 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.

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 make to amend or restrict the use or disclosure of your health information or to have us communicate 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Contact Officer: William T. Harris, Jr., DDS

Telephone: (501) 455-6100

Fax: (501) 455-6103

Website: www.harrisandreynoldsdental.com

Address: 9801 Stagecoach Rd., Little Rock, AR 72210

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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 the acknowledgement

_____ Other (Please Specify)

_____

_____

_____