KURT SOLERA D.D.S. PA
PO BOX 3237 ◆ BELLA VISTA, AR 72715
479.855.1855 FAX 479.876.1855

Patient Name: _____ Date: _____
Preferred name or nickname: _____ Marital Status: _____
Address: _____ Date of Birth: _____
City: _____ St _____ Zip _____ SSN: _____
Telephone: _____ E-mail: _____
Work phone: _____ Do you receive texts? _____
Cell phone: _____ Spouse: _____

Responsible party if other than patient (must have DOB & member ID to file insurance for patient):
Name: _____
Relationship to patient: _____ Marital Status: _____
Address: _____ Date of Birth: _____
City: _____ St _____ Zip _____ SSN: _____
Telephone: _____ E-mail: _____
Work phone: _____ Do you receive texts? _____
Cell phone: _____ Spouse (if other than patient): _____

Responsible Party Employer: _____ May we call you at work? _____
Address: _____ Occupation: _____
City: _____ St _____ Zip _____

Primary Insurance Company	Secondary Insurance Company
Ins Co Name	Ins Co Name
Group #	Group #
Policy Holder	Policy Holder
Policy Holder DOB	Policy Holder DOB
Policy Holder Member ID	Policy Holder Member ID

Please provide the receptionist with a copy of your insurance card(s) and a photo id.

Who may we thank for referring you? _____

PAYMENT OPTIONS:

INSURANCE: As a courtesy, we process insurance claims for our patients. On the date of service we will *estimate* the patient's deductible and co-payment, which is due at that time. Actual cost may vary from the estimate. Your insurance company may pay a different amount than we expect. If this happens the patient is responsible to pay the difference. Any insurance payment not received by the office within 60 days becomes the responsibility of the insured/responsible party.

INITIAL PAYMENTS: Payment for each visit is due at the time of treatment. We are sensitive to the fact that some people may not be able to pay cash at this time. Therefore for our patients' convenience, we now accept VISA, MASTERCARD, and DISCOVER. If a particular procedure requires more than one visit, we allow the patient to pay half at the initial visit and the balance when treatment is complete.

I understand and agree to these terms, and I assign my dental insurance payments to this office:

_____
Patient Signature

MEDICAL HISTORY

FOR
6165--NEW PATIENT
Birth Date:

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.

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 explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ 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?
- ☐ Nursing?
- ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

☐ Other If yes, please explain: _____

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

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

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 _____

KURT SOLERA DDS PA
NOTICE OF PRIVACY PRACTICES

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 and make it available to you in writing about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect October 1 2003 and remains in effect until we replace it. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use/disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use/disclose your health information to a physician, pharmacist, or other healthcare provider providing treatment to you.

Payment: We may use/disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use/disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment, reviewing the competence or qualifications of healthcare professionals, conducting training programs, accreditation, certification, licensing or credentialing activities.

Persons Involved In Care: We may use/disclose health information to notify a family member or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use/disclosure of your health information, we will provide you with an opportunity to object to such uses/disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using 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 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 use/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.

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 counter-intelligence, and other national security activities We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use/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 that you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain from our office a form to request access. We will charge you a reasonable cost based fee for expenses such as copes 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 $0.75 for each page and $10.00 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 alternate format, we will charge a cost-based fee for providing your health information in that format.

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, health care 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 those 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).

Alternate Communication: You have the right to request that we communicate with you about your health information by alternate means or to alternate locations. You must make your request in writing. Your request must specify the alternate means or location, and provide satisfactory explanation how payments will be handled under the alternate means or location you request.

Encryption Policy: As a rule we do not initiate communication with patients via e-mail. You may e-mail electronic protected health information to this office AT YOUR RISK. We will respond to your e-mail only if, YOU AGREE TO RECEIVE AN UNENCRYPTED E-MAIL RESPONSE and we receive a request in writing from you. We do not encrypt e-mail and the messages may not be secure.

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 COMPLAINTS AND OTHER NOTICES

You may authorize us to use/disclose your information for purposes or to individuals other than those included in this document, and you may revoke that authorization at any time. Authorization and revocation of such authorization must be in writing.

Questions and Complaints should be directed to the Practice Manager of Kurt Solera, D.D.S. PA through one of the following means:

Telephone: 479.855.1855
Fax: 479.876.1855
Address: P.O. Box 3237, Bella Vista, Arkansas 72715