



REGISTRATION FORM

(Please Print)

Today's date:	
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Name preferred	Email address:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Social Security no.:	Home phone no.: ()
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City:	State:	ZIP Code:	Cell phone no.: ()
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Occupation:	Employer:	Employer phone no.: ()
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Chose Magnolia Dental Care because/Referred by (please check one box):

Family _____ Friend _____
 Close to home/work Insurance Plan Internet Other _____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Phone no.: ()
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Is this person a patient here? Yes No

Occupation:	Employer:	Employer address:	Employer phone no.: ()
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Is this patient covered by insurance? Yes No

Dental Insurance Provider: _____ Employee: _____

Subscriber's name:	Subscriber's SS#:	Birth date: / /	Group no.:	Contract no.:
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Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group No.:	Contract No.:
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Patient's relationship to subscriber: Self Spouse Child Other Student Full-time / Part-time College:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone no. 1: ()	Phone no. 2: ()
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The above information is true to the best of my knowledge. If the above named is a minor, I also give my permission for treatment. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or the insurance company to release any information required to process my claims.

Patient/Guardian signature	Date
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MEDICAL HISTORY

(Please Print)

Today's date:	Patient's Name:		
Have you ever had any of the following conditions?			
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding/Sore Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shifting of Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain (angina)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Biting Cheeks or Lips	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clicking/Popping Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Opening or Closing Jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Blisters on Lips/Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling/Lumps in Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food Impaction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clenching/Grinding Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Bite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to Hot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitive to Sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain when chewing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unpleasant Taste/Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use/History/# of years used	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cigarettes _____	
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> E-Cig _____	
Immune System Disorders (AIDS, HIV, ARC)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Smokeless _____	
Autoimmune Disorders (lupus, Sjogrens)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	
Stomach Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Intestinal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Are you presently taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please List:	_____
Are you presently taking any Anticoagulants, blood thinners or Bisphosphonates (for osteoporosis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please List:	_____
Have you had complications from local anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Explain:	_____
Are you allergic to any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please List:	_____
Are you Pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date:	_____
Are you currently under the care of a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Why:	_____
Do you have any artificial joints or heart valves?	<input type="checkbox"/> Yes <input type="checkbox"/> No		_____
Why are you seeking Dental Treatment?			_____

Signature of Patient or Guardian: _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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 acknowledgement
- Other (Please specify)



NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments.

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

PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of **Magnolia Dental Care, PC** ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact **Magnolia Dental Care, PC's** Privacy Official at:

**Magnolia Dental Care, PC
720 Oak Circle Drive W, Suite 400
Mobile, AL 36609
251-308-2923**

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected 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.

IV. Last Revision Date

This Notice was last revised on January 15, 2016.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may 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.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. 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.

4. 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, phone call, voice message, text or email.

5. 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.

6. 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.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. 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 HIPAA.

2. 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.

3. 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.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

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

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. 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 HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review 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 a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is 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 is incorrect or incomplete.

C. Right to 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 your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and 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 that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) 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 HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may 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.

F. Right to 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.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our 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 is January 15, 2016.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.