Pulver
DENTAL CARE
DR. D.W. PULVER
DR. A.M. PULVER

PATIENT REGISTRATION

Name: _____ Date: _____
First MI Last

Preferred Name: _____

RESPONSIBLE PARTY: *(if someone other than the patient)*

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell # _____

Birth Date: _____ Social Security #: _____ Email: _____

PATIENT INFORMATION:

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Ext: _____ Cell # _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Birth Date: _____ Social Security #: _____ Email: _____

Employment Status: ❑ Full Time ❑ Part Time ❑ Retired Student Status: ❑ Full Time ❑ Part Time

Whom may we thank for referring you: _____

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Insurance Company Phone #: _____

SECONDARY INSURANCE INFORMATION:

Name of Insured: _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured Soc. Sec #: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Insurance Company Phone #: _____

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% will be assessed each month on the total balance unpaid and owed. In the case of default on payment of this account, I agree to pay collections costs, interest and reasonable attorney fees incurred in the attempt to collect on this amount or any future outstanding account balances.

I certify that I have read and fully understand this authorization for dental treatments.

X _____ Date _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR (I authorize dental treatment for myself/my child and agree to pay all related professional fees. Estimated fees not covered by my dental insurance will be paid at the time of service. Any remaining fees due, after insurance payment, will be promptly paid upon notification from this office.)

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MEDICAL HISTORY

Patient Name:_____

Birth Date:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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: _____
Do you suffer from frequent or infrequent headaches?	❍ 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	_____
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	
Do you clench your jaw, feel yourself grinding your teeth or chew gum frequently?	❍ Yes ❍ No	If yes, please explain: _____
Do you suffer from facial discomfort (TMD), including sore jaw or tightness/popping in the jaw joint area?	❍ Yes ❍ No	_____ If yes, please explain: _____
Do you feel like you have a gummy smile or are just overall unhappy with your smile?	❍ Yes ❍ No	_____ If yes, please explain: _____

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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Pulver Dental Care / 501 East Commercial Ave./ Lowell, IN 46356 219-696-4940 drpulver@earthlink.net

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN 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 04/14/2003, 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 and 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and 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 healthcare 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, your 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 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, we will charge you $0._____ for each page, $.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 alternative format, we will charge a cost-based fee for providing your 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 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: Pulver Dental Care/ D.W.Pulver D.D.S._____

Telephone. 219-696-4940_____Fax: 219-696-4800_____

E-mail. dwpulver@comcast.net_____

Address 501 East Commercial Avenue, Lowell, Indiana 46356_____

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

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 acknowledgment 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)

_____
_____
_____
_____
_____