Kurt Solera, D.D.S. P.A.

PO Box 3237, Bella Vista, AR 72715

Office (479) **855.1855** | Fax (479) **876.1855**

PATIENT NAME:

Preferred Nickname:

Address:

Date of Birth: / / (MM/DD/YYYY)

City: State: Zip:

SSN:

Home Phone:

Marital Status:

Work Phone:

Spouse Name:

Cell Phone:

Email Address:

☐ It is okay to communicate with me by text ☐ It is okay to communicate with me by email

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RESPONSIBLE PARTY, IF OTHER THAN PATIENT *(must have DOB and Member ID to file insurance for patient)*

Name:

Relationship to Patient:

Address:

Date of Birth: / / (MM/DD/YYYY)

City: State: Zip:

SSN:

Home Phone:

Marital Status:

Work Phone:

Spouse Name:

Cell Phone:

Email Address:

☐ It is okay to communicate with me by text ☐ It is okay to communicate with me by email

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RESPONSIBLE PARTY EMPLOYER

Employer:

Occupation:

Address:

Phone Number:

City: State: Zip:

May we contact you at work? ☐ Yes ☐ No ☐ Emergency Only

PRIMARY INSURANCE	
COMPANY NAME	
GROUP #	
POLICY HOLDER	DOB
MEMBER ID	

SECONDARY INSURANCE	
COMPANY NAME	
GROUP #	
POLICY HOLDER	DOB
MEMBER ID	

** Please provide the receptionist with a copy of your insurance card(s) and 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:

Signature of Patient, Parent, or Guardian

X **Date:**

Patient Name: Birthdate: Date Created:

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MEDICAL HISTORY

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 physicians care now?	Yes	No	If yes	
Have you ever been hospitalized or had a major operat	Yes	No	If yes	
Have you ever had a serious head or neck injury?	Yes	No	If yes	
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	If yes	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	Yes	No	If yes	
Are you on a special diet?	Yes	No		
Do you use tobacco?	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 Sulfa Drugs Local Anesthetics

Do you use controlled substances?	Yes	No	If yes	
Other?			If yes	

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

AIDS / HIV Positive	Yes	No	Cortisone Medicine	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 Problems	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
Chemotheraphy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsilitis	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 Pacemaker	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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to my medical status.

Signature of Patient, Parent, or Guardian

X **Date:**

Patient Name:	Birthdate:	Date Created:

Kurt Solera, D.D.S. P.A.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature of Patient, Parent, or Guardian

X **Date:**

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

_____

AMBULATORY CONSENT FORM

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____

I, _____, consent to medical examination, laboratory procedures and other studies ordered by Kurt Solera, D.D.S. P.A. or other healthcare providers under Dr. Solera's supervision.

I authorize Kurt Solera, D.D.S. P.A. or any employee or contract laborer authorized by Dr. Solera to release any medical or other information necessary to process insurance claims for myself or any dependent covered by my and/or my spouse's insurance. I authorize this information to be released to my and my spouse's employer and/or pre-certification company, should this be a requirement for claims processing.

I authorize direct payment of insurance to Kurt Solera,. DDS PA. I understand that I am responsible for any amount not paid by insurance.

A copy of this authorization shall be considered as effective and valid as the original.

You may discuss my medical information with the following individual(s) as my personal representative(s). (Please list the name of any person with whom you wish us to be able to discuss your treatment, care and personal information. This could be a spouse, your child, or a parent. If you wish to have more than two personal representatives, please notify office attendant for another form.)

_____ _____

Name of 1st personal representative Relation to patient

_____ _____

Name of 2nd personal representative Relation to patient

I HAVE BEEN OFFERED A COPY OF THE PRIVACY NOTICE FOR KURT SOLERA, DDS PA.

_____ _____

Signature of Insured (or Authorized Person) 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