Belle Chasse Family Dentistry
8951 Highway 23
Belle Chasse, LA 70037

PATIENT NAME: _____ TODAY'S DATE: _____

Birthdate: _____ SSN: _____
Marital Status: _____ (M) or (F)
Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____
Cell: _____
Employer: _____
Email address: _____
Drivers Lic: _____

Primary Insurance Information:
Subscriber name: _____
Subscriber SSN: _____
Birthdate: _____
Relationship to pt: _____
Insurance name: _____
Insurance phone #: _____
Group id: _____
Insurance id number: _____

Secondary Insurance Information:
Subscriber name: _____
Subscriber SSN: _____
Birthdate: _____
Relationship to pt: _____
Insurance name: _____
Insurance phone #: _____
Group id: _____
Insurance id number: _____

Patient Privacy Practices Notice

Acknowledgement of Notice of Privacy Practice: I have been given my copy of the Patient Privacy Notice as required under the final privacy rules issued by HHS pursuant to the Health Insurance Portability and Accountability act of 1996 (HIPPA). This notice outlines information about patient rights and Belle Chasse Family Dentistry rights and legal duties and privacy practices with respect to protected health information. I will review the information enclosed.

Since the information in this notice is necessarily subject to change by action of Belle Chasse Family Dentistry, Federal or State law, it is understood that any policies as listed herein may be modified, superseded or eliminated, and these changes may be implemented even though they may not have been communicated, reprinted or substituted in this notice.

_____ _____
Name of patient printed Date

_____
Signature or Patient, Parent or Responsible party

Relationship to Patient: _____

Have you thought about improving the appearance of your smile? Yes or No
Would you like to straighten your teeth? Yes or No
Do you have spaces that you don't like? Yes or No
Would you like to change the color of your teeth? Yes or No
Are your teeth chipped? Yes or No
Are your teeth wearing on the biting surfaces? Yes or No

What would you change about your teeth: (circle all that apply)
COLOR SHAPE SIZE STRAIGHTEN OTHER:

Have you had orthodontic work in the past? Yes or No
Do you clench or grind your teeth while asleep or awake? Yes or No

Patient Signature: _____ Date: _____

Belle Chasse Family Dentistry

Medical History

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ 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
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

Pregnant?	○ Yes ○ No	Trying to get pregnant?	○ Yes ○ No	Nursing	○ Yes ○ No

Are you allergic to any of the following?

Aspirin	○ Yes ○ No	Penicillin	○ Yes ○ No	Codeine	○ Yes ○ No	Acrylic	○ Yes ○ No
Metal	○ Yes ○ No	Latex	○ Yes ○ No	Sulfa Drugs	○ Yes ○ No	Local Anesthetics	○ Yes ○ No

Please list all other allergies: ☐ If yes

Circle if you have, or have had, any of the following:

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ 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
Herpes	○ Yes ○ No	Emphysema	○ Yes ○ No	Arthritis	○ 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	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Frequent Cough	○ Yes ○ No
Kidney Problems	○ Yes ○ No	Frequent Diarrhea	○ 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	Cancer	○ Yes ○ No
Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Mitral Valve Prolapse	○ 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	Congenital Heart Disorder	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Ulcers	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	Autism	○ Yes ○ No	Head Injury	○ Yes ○ No
High/Low Blood Pressure	○ Yes ○ No	Blood Disorders	○ Yes ○ No	Sleep Apnea	○ Yes ○ No
Chemotherapy/Radiation	○ Yes ○ No				

Have you ever had any 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 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:

X Date:_____

HIPAA Release Form for Dental Records

Name:_____**Date of Birth** ___/___/____

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

( ) Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

X_____ **Date:** ___/___/____
Signature of patient, parent or responsible party / Relationship to patient_____
Print Name: _____

Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All co-payments are due at the time services are rendered.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patients and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
In this office we believe in providing our patients with the utmost in care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings and the patient is responsible for any difference in cost.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

*A service charge of $50.00 per month on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
*Appointment policy: If you find it impossible to keep your appointment, for consideration of other's needs, we ask for a 24 hour notice. Appointment's cancelled or missed without a 24 hour notice are subject to a missed appointment fee.

X-rays and Photographs:
I authorize Belle Chasse Family Dentistry and his team to take any images, x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPPA regulations).

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read and agreed to the above terms of treatment.

X_____ **Date:** __/___/___

Signature of patient, parent or responsible party / Relationship to patient_____
Print Name:_____

Belle Chasse Family Dentistry

8951 Hwy 23 Belle Chasse, LA 70037
504-394-6200

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Stuart J. Guey Jr. DDS ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

Shelly Benoit
8951 Hwy 23
Belle Chasse, LA 70037
504-394-6200 Phone
504-394-6290 Fax
shelly@drguey.com Email

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 March 23, 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 March 23, 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.