MORRISON DENTAL GROUP

Patient Registration Form

PATIENT INFORMATION: Date: _____

Chart#: _____ Email for Appointment Reminders: _____

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

Physical Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: _____ Work Phone: _____ Cell: _____

Sex: Male ☐ Female ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ Date of Birth: _____ Age: _____

Occupation: _____ If Student, School: _____

If Employed, Employer: _____ Address: _____

Spouse's Name: _____ SS#: _____ Employer: _____

I was referred to this practice by: _____

RESPONSIBLE PARTY (if different from the patient):

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

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Employer: _____ Address: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____ Phone#: _____

Claims Address: _____

Policy ID#: _____ Group#: _____ Plan#: _____

Policyholder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Employer: _____ Address: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____ Phone#: _____

Claims Address: _____

Policy ID#: _____ Group#: _____ Plan#: _____

Policyholder's Name: _____ SS#: _____

Date of Birth: _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐ Other ☐ _____

Employer: _____ Address: _____

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.

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (Check boxes that apply):

☐ Heart Murmur	☐ Epilepsy	☐ Blood Thinners
☐ High Blood Pressure	☐ Headaches	☐ Swollen Neck Glands
☐ Low Blood Pressure	☐ Hepatitis, Jaundice or Liver Disease	☐ Rheumatic Fever
☐ Circulatory Problems	☐ Cancer	☐ Sinus Problems
☐ Nervous Problems	☐ Psychiatric Care	☐ AIDS/HIV
☐ Radiation Treatment	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Artificial Heart Valves or Joints	☐ Allergies to Anesthetics	☐ Stroke
☐ Recent Weight Loss	☐ Allergies to Medicine or Drugs	☐ Ulcer
☐ Latex Allergy	☐ General Allergies	☐ Venereal Disease
☐ Diabetes	☐ Blood Disease	☐ Chemical Dependency
☐ Respiratory Disease	☐ Arthritis	☐ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication? _____

If so, what? _____

Have you ever responded adversely to medical or dental treatment? _____

Are you taking any medication at this time? _____ If so, what? _____

_____

Are you under the care of a physician? ☐ Yes ☐ No

For what conditions? _____

If patient is a child, what is his/her weight? _____

(Woman) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____

Do you have x-rays at another dental practice? _____

MEDICAL UPDATE: I have read my health history above and confirm that it adequately reflects my medical condition, past and present.

DATE	EXCEPTIONS OR CHANGES	PATIENT"S SIGNATURE	DOCTOR'S INITIALS

MEDICAL UPDATE: I have read my health history above and confirm that it adequately reflects my medical condition, past and present.

DATE	EXCEPTIONS OR CHANGES	PATIENT"S SIGNATURE	DOCTOR'S INITIALS

MEDICAL UPDATE: I have read my health history above and confirm that it adequately reflects my medical condition, past and present.

DATE	EXCEPTIONS OR CHANGES	PATIENT"S SIGNATURE	DOCTOR'S INITIALS

MEDICAL UPDATE: I have read my health history above and confirm that it adequately reflects my medical condition, past and present.

DATE	EXCEPTIONS OR CHANGES	PATIENT"S SIGNATURE	DOCTOR'S INITIALS

MORRISON DENTAL GROUP

1131 Professional Drive
Williamsburg, VA 23185
(T) 757-220-0330
(F) 757-220-9067

7151 Richmond Road Ste. 305
Williamsburg, VA 23188
(T) 757-258-7778
(F) 757-258-5185

4009 Main Street
Chincoteague, VA 23336
(T) 757-336-1260
(F) 757-336-1262

WELCOME TO THE OFFICE

Our staff appreciates the selection of this office to service your dental health needs. Our goal in this practice is to provide the very best possible dental care for our patients so that each of you may enjoy optimal dental health throughout your lifetime.

During your first visit a thorough examination will be completed. This will include x-rays or other aids that are necessary in making an accurate diagnosis. We will determine and discuss your dental treatment.

Except for emergency situations, you can expect us to be on time for your appointment and we appreciate the same courtesy. No charge will be made for rescheduling your appointment, provided 24 hours notice is given so that your time can be given to another patient.

FINANCIAL POLICY

To avoid any misunderstandings concerning fees, you will receive an estimate of the proposed services prior to treatment and we require payment at the time of service. Our goal is to provide you with the best care possible and we strongly believe that a clear understanding of your financial responsibilities is vital to a healthy relationship with our practice. To assist you in this, several payment options are available for your convenience.

1. CASH IN ADVANCE or at the time service is rendered is customary in our office, unless other financial arrangements have been made.
2. VISA, MASTERCARD, DISCOVER.
3. Care Credit

After 60 days a 1.5% finance charge will be applied to the unpaid balance on your account. This includes unpaid insurance claims.

In the event this account is referred for legal action, the patient agrees to pay the cost of court, collection and 25% attorney fees.

DENTAL INSURANCE

Please understand that your insurance policy is an arrangement made between you and your carrier. To avoid any confusion **please make sure your insurance company will allow you to visit us**. Our practice deals with many different insurance plans and thus cannot guarantee that a certain amount of any charge will be covered. Health plans differ and can often cover the same services at different payment schedules. The best possible way to proceed is to be in contact with your insurance company and understand the details of your plan coverage. Please do not hesitate to ask our front desk for assistance. We will provide codes for dental services which you can then give to your provider to learn about coverage and payments.

Co-payments, deductibles, and amounts not covered by your insurance are your responsibility. Please note that due to our own contracts with insurance companies **we are unable to waive co-payments or deductibles**. Our practice must accept negotiated charges with some insurance carriers due to existing contracts; however this is not applicable to all insurance companies. Therefore, it is possible that what your insurance carrier deems "customary" and what we charge does not match up. In those cases, the balance is your responsibility unless your insurance company instructs us to write off the difference.

If you have no dental insurance you are responsible for the entirety of your balance. If you cannot pay off the balance in full at the time of your visit, please speak with our receptionist to discuss Care Credit.

Signed _____ Dated_____

ROBERT F. MORRISON DMD P.C.

{NAME OF PRACTICE}

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 04/10/03, 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 $0.75 for each page, $25 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: DR. ROBERT MORRISON

Telephone: 757 220 0330 Fax: 757 220 9067

E-mail:

Address: 1131 Professional Drive
Williamsburg, VA 23185

© 2002 American Dental Association

All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

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

Morrison Dental Group 

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: _____ Date: _____

Provider Name: _____
Provider

Address: _____
Provider

Fax Number: _____ Phone Number: _____
Provider Provider

Information or Records to be disclosed: _____

Please disclose health information and send records to*:

☐ Morrison Dental Group 7151 Richmond Rd. Ste 305 Williamsburg, VA 23188 Phone: (757) 258-7778 Fax: (757) 258-5185	☐ Morrison Dental Group 1131 Professional Drive Williamsburg, VA 23185 Phone: (757) 220-0330 Fax: (757) 220-9067	☐ Morrison Dental Group 4009 Main Street Chincoteague, VA 23336 Phone: (757) 336-1260 Fax: (757) 336-1262

*Please send information to the office that is checked above, or e-mail us at

records@morrisondentalgroupva.com

As the person signing this consent, I understand that I am giving my permission to the above named provider for disclosure of confidential health care records.

☐ No I do not have x-rays at any other provider.

Signature of Patient: _____ Date: _____

Chart #: _____

Morrison Dental Group

HIPAA Notice of Privacy Practices
Acknowledgement of Receipt

Morrison Dental Group will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regard to protected health information. The terms of this notice may change with time, and we will post the current notice at our facility and have copies available for distribution

I also give **Morrison Dental Group** permission to speak to the following people (if any) regarding my health information:

_____

_____

_____

I hereby acknowledge that I have and read a received a copy of Morrison Dental Groups HIPAA Notice of Privacy Practices.

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

Name of Patient: _____

FOR OFFICE USE ONLY:

Signed form received by: _____

Acknowledgement refused: _____

Efforts to obtain: _____

_____

Reason for refusal: _____

_____

11/14

Williamsburg
1131 Professional Drive
Williamsburg, VA 23185
(757) 220-0330

Norge
7151 Richmond Road, Suite 305
Williamsburg, VA 23188
(757) 258-7778

Chincoteague
4009 Main St.
Chincoteague, VA 23336
(757) 336-1260

www.MorrisonDentalGroup.com