MDN

DR. MARK DYE
Cosmetic & Family Dentistry

MARK N. DYE DMD, LLC
310 Eisenhower Drive, Building 14
Savannah, GA 31406
OFFICE 912.355.2424 FAX 912.356.9149
dr.dye@thesavannahdentist.com

PATIENT REGISTRATION

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Name _____ Nickname _____
(FIRST) (LAST)

Male ☐ Female ☐ Date of Birth M/D/Y ____/____/____ Social Security # _____

Home Address _____

City _____ Postal Code _____

Home Number _____ Cell Number _____

Business Number _____ Ext. _____ E-mail Address _____

How would you like to have your appointments confirmed? ☐ Home ☐ Cell ☐ Business ☐ Email ☐ Other _____

Marital Status _____ Children ☐ Yes / ☐ No

Occupation _____ Employer _____

Person Responsible for Payment? Myself / Father / Mother / Spouse / Other _____
Do you have Dental Insurance? YES ☐ NO ☐

PRIMARY INSURANCE

☐ Myself Insured Name _____

Employer _____ Date of Birth M/D/Y ____/____/____ Relationship _____

Address (Same as above☐) _____ City _____ Postal Code _____

Insurance Company Name _____ Policy/Plan/Contract # _____

ID or Certificate Number _____ Policy Holder SS# _____

SECONDARY INSURANCE

Insured Name _____

Employer _____ Date of Birth M/D/Y ____/____/____ Relationship _____

Address (Same as above☐) _____ City _____ Postal Code _____

Insurance Company Name _____ Policy/Plan/Contract # _____

ID or Certificate Number _____ Policy Holder SS# _____

IN CASE OF EMERGENCY PLEASE CONTACT

_____ At # _____ Relationship _____

Assignment of Insurance Benefits and Release of Information

I, the undersigned, certify that I (or my dependants) have dental insurance coverage with _____
Name of Insurance Company

and assign directly to Mark N. Dye, DMD, LLC all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance whether manual or electronic.

Responsible Party Signature _____ ***Date*** _____

Medical History

Mark N Dye DMD

Patient Name_____

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

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
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
Other? ❑		If yes	
Do you use controlled substances?	○ Yes ○ No	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
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ 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 ○ Yes ○ No If yes

Referral Information

Whom may we thank for referring you to our practice? ❑ Another patient, friend ❑ Another patient, relative

❑ Dental Office ❑ Yellow Pages ❑ Newspaper ❑ School ❑ Work ❑ Other _____

Name of person or office referring you to our practice: _____

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: _____

Our Office and Financial Policies

Thank you for choosing us as your dental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. If you have any questions, please feel free to ask any staff member for more information.

APPOINTMENTS
Your appointments are scheduled to respect your time. We reserve a significant amount of time and reserve a specific room for your care, and make every effort to see you at the appointed time. We appreciate your promptness and consideration in not changing your reserved time. However, if you must change an appointment, a ***48-hour notice*** Is expected. A fee may be applied for appointments missed without notice. Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.

INSURANCE
As a courtesy to you, we accept assignment of insurance benefits from most insurance companies. However, **we do require you to pay your deductible and/or "estimated patient portion" at the time of service**. The balance is your responsibility whether your insurance pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Patients who carry dental insurance should remember that all dental services performed are charged directly to the patient and not the insurance company. If you have dental insurance, you must provide us with your dental insurance card and a claim form If needed. We must be able to verify coverage before we can accept assignment of benefits. Please note that dental insurance plans are different from your medical insurance. Each plan has different yearly deductibles and benefits. Most insurance plans will pay, at most, 80% of Basic procedures and 50% of Major procedures. When possible, we will submit a dental pre-estimate to your insurance company for review. This will allow you to know the exact amount that the insurance company will pay. However, this office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that I am responsible for reading and understanding my dental Insurance benefits. _____
Initial

USUAL AND CUSTOMARY RATES
Please be aware that some of our services may be "non-covered", subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations Imposed by the insurance company. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive. ***You are responsible for any balance left unpaid by your insurance company.*** The adult accompanying a minor is responsible for full payment.

PAYMENT OPTIONS AND ACCOUNT INFORMATION
If a balance is over 30 days, a billing fee will be added at the rate of 1.5% per month of the total balance. In the event we receive a returned check for Insufficient funds or a closed account, there will be a $25.00 fee charged to your account. Collection fees of 35% of the account balance will be added to any balance turned over for collection purposes.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, and DISCOVER

WE ALSO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL (CareCredit)
If you wish to utilize this option, please ask at the front desk for an application.

Thank you for understanding our guidelines. Please let us know if you have any questions or concerns.
I have read, understand, and agree to the above office and financial policies.

X _____ _____
Signature of patient or responsible party Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Mark N. Dye, DMD, LLC to release/receive the following information from the records of:

Patient Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____

To be released to:

Name: _____ Telephone Number: _____

Address:_____ City: _____ State: _____ Zip: _____

Information to be released: (Circle all that apply)

Entire Record Lab Results Assistant Notes Medication Record

X-Rays

Other: _____

For dates of service rendered _____ through _____

Records are to be released for the purpose of: _____

I understand that I can revoke this authorization by providing written notice to the office manager of Mark N. Dye, DMD, LLC at the address listed above. I also understand that if the information has been released upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON THE RELEASE OF HISTORY OF ILLNESS OR DIAGNOSTIC OR TREATMENT INFORMATION, INCLUDING BUT NOT LIMITED TO ANY INFORMATION CONTAINED IN MY RECORD CONCERNING TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, MENTAL ILLNESS, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS OR AIDS.

I understand that I am waiving my rights to privacy by releasing my information to the parties listed above and this information may be redisclosed to the receiving party.

I understand that this Release will expire within ninety (90) days from the date listed below.

Patient Signature_____ Date _____

Patient's Guardian or Capacity _____ Date _____

Relationship to Patient _____

For Office Use Only:

Request completed by: _____

Method of Release: Mail Pick-Up Fax

Mark N. Dye, D.M.D., LLC
310 Eisenhower Dr Bldg 14
Savannah, GA 31406
912-355-2424

BROKEN APPOINTMENT CONTRACT

I understand and agree that it is my responsibility to provide the office a **MINIMUM** of **24 hours notice** if I need to either cancel or reschedule my appointment.

Furthermore, I understand that I will automatically be billed a **$30** Broken Appointment fee if this criteria is not met.

Print Name_____

Signature_____

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 (01/01/2007), 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 $25.00. $.50 for each page, $25.00 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. 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. Mark N. Dye

Telephone: 912-355-2424 Fax: 912-356-9149

Address: 310 Eisenhower Drive, Building 14, Savannah, GA 31406

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Mark N. Dye

Telephone: 912-355-2424 Fax: 912-356-9149

Address: 310 Eisenhower Drive, Building 14, Savannah, GA 31406

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____