Welcome To Mangan Dental Group

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

ABOUT YOU

Date: _____

Patient Name: _____
Last First MI

Nickname: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____

_____
City State Zip

Home Phone: (_____) _____

Work Phone: (_____) _____Ext: _____

Cell Phone: (_____) _____

Email Address: _____

Referred By: _____

Employer: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

RESPONSIBLE PARTY

Person ultimately responsible for account such as parent or legal guardian.

Name: _____

Relation: _____

Billing Address: _____

_____
City State Zip

Birthdate: _____ SS#: _____

Home Phone: (_____) _____

Work Phone: (_____) _____Ext: _____

Cell Phone: (_____) _____

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone: (_____) _____

Work Phone: (_____) _____Ext: _____

Cell Phone: (_____) _____

INSURANCE INFORMATION

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
City State Zip

800#: (_____) _____

Insured's ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: _____

Insured's Employer: _____
or ☐ Self Insured Policy

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
City State Zip

800#: (_____) _____

Insured's ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ Birthdate: _____

Insured's Employer: _____
or ☐ Self Insured Policy

I authorize Mangan Dental Group and its associates to furnish any information to my insurance company concerning my care as applicable and that the above information is true.

Patient or Guardian: _____ Date: _____

Dental History

What prompted you to seek dental care at this time?

☐ Routine Care, No Problems ☐ I have tooth pain ☐ I have gum problems

☐ I need to have teeth fixed or replaced ☐ Other, specify:

How long has it been since your last thorough dental exam?

☐ Less than 6 months ☐ 6-12 Months ☐ 1 – 2 Years ☐ Never/I don't know

Have you recently (within the past year or two) had any of the following?

Dental Cleaning	Bite wing x-rays	Full Mouth x-rays	Panoramic x-ray
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

How often do you go to the dentist for routine cleanings and examinations?

☐ Never ☐ Rarely ☐ Every few years ☐ Yearly ☐ Every 6 months ☐ More than twice per year

How often do you brush your teeth?

☐ Never ☐ Rarely ☐ Occasionally ☐ 1 – 2 times weekly ☐ Daily ☐ More than once daily

How often do you floss your teeth?

☐ Never ☐ Rarely ☐ Occasionally ☐ 1 – 2 times weekly ☐ Daily ☐ More than once daily

Please answer the following:	Check One:	Explain "Yes" answers
Have you had any discomfort from your teeth or gums lately?	☐ Yes ☐ No	
Are your teeth sensitive to hot or cold?	☐ Yes ☐ No	
Would you like to change anything about your smile?	☐ Yes ☐ No	
Do your teeth need to be whiter?	☐ Yes ☐ No	
Do your gums bleed when you brush or floss?	☐ Yes ☐ No	
Have your teeth shifted in position or alignment in the past year?	☐ Yes ☐ No	
Does food often get stuck in between certain teeth?	☐ Yes ☐ No	
Does your jaw pop when you open or close your mouth?	☐ Yes ☐ No	
Do you habitually grind or clench your teeth?	☐ Yes ☐ No	
Do you now wear or expect to wear dentures someday?	☐ Yes ☐ No	
Do you have missing teeth you want to get replaced?	☐ Yes ☐ No	
Do you habitually chew on anything?	☐ Yes ☐ No	
Do you frequently snack on sweets?	☐ Yes ☐ No	
Does going to the dentist scare you?	☐ Yes ☐ No	
Have you ever had a particularly bad experience at the dentist?	☐ Yes ☐ No	

Check the dental procedures you have experienced:

☐ Cleanings	☐ Sealants	☐ Root Canals	☐ Extractions
☐ Fillings	☐ Bleaching	☐ Deep Scaling	☐ Other Oral Surgery
☐ Braces	☐ Crowns	☐ Periodontal Surgery	☐ TMJ Treatment
☐ Bonding/Veneers	☐ Bridges	☐ Bite Adjustment	☐ Dental Implants

Is there anything else about having dental treatment that you would like us to know?

Medical History

Vital Signs (Answer if known, otherwise leave blank)					
Height:		Resting Pulse:		Total Cholesterol:	
Weight:		Respiratory Rate:		Fasting Blood Sugar:	

If female, please answer the following:					
Are you taking Birth Control Pills?					
Are you pregnant?		If Yes, # of weeks		Due Date:	
Are you nursing?					

Physician (List your Primary Care Physician / Family Doctor)			
Name:		City, State:	

Conditions – Check all that are applicable, otherwise ☐ None					
	Abnormal Bleeding		Frequent Headaches		Seizures
	Allergies		Glaucoma		Shingles
	Anemia		Heart Attach		Sickle Cell Disease
	Angina Pectoris		Heart Murmur		Sinus Problems
	Arthritis		Heart Surgery		Stroke
	Artificial Heart Valve		Hemophilia		Thyroid Problems
	Asthma		Hepatitis (A, B, or C)		Tobacco Use
	Cancer – Chemotherapy		High Blood Pressure		Tuberculosis
	Chronic Cough		HIV+ AIDS		Ulcers
	Colitis		Immunosuppressive Drugs		Venereal Disease
	Congenital Heart Defect		Joint Replacement	**Allergies - ☐ None**	
	Congestive Heart Failure		Kidney Problems		Aspirin
	Cosmetic Surgery		Liver Disease		Codeine
	Daily Alcohol Use		Low Blood Pressure		Dental Anesthetics
	Diabetes		Mitral Valve Prolapse		Erythromycin
	Difficulty Breathing		Pace Maker		Jewelry
	Eating Disorder		Psychiatric Problems		Latex
	Emphysema		Radiation Therapy		Metals
	Epilepsy		Recreational Drug Use		Penicillin
	Fever Blisters		Rheumatic Fever		Tetracycline
					Other

Current Medications Information – List all medications or check ☐ None Taken

Medicine Name	Strength	Frequency	Taken for what condition?

Is there any disease, condition, or problem that you think this office should know about that is not covered above? ***If yes, please describe below...***

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all of the questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient or Guardian: _____ Date: _____

POLICIES OF MANGAN DENTAL GROUP

PAYMENT POLICY

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made prior to treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges incurred.

_____
Initial

DENTAL INSURANCE POLICY

Payment is due at the time of treatment, unless other arrangements have been made prior to treatment. Parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child or patient for whom you have legal responsibility. As a courtesy to our patients we will file most dental insurances with your insurance company. However, filing a claim with your insurance company does not relieve you from your responsibility for the payment of all charges. For some insurance we are able to estimate the benefits from your insurance plan and may require that you pay the estimated patient portion in lieu of the full treatment balance on the day of treatment. Our estimates are not a guarantee of payment and any balance resulting from a lower reimbursement from your insurance than initially estimated is due in full. In addition, if the insurance company fails to make payment within 60 days, the entire balance becomes due from the patient.

_____
Initial

APPOINTMENT POLICY

In order to offer the best dental services to our patients our office reserves individual appointment times for every patient. Often, our practitioners spend significant time preparing for your scheduled appointment. Should something occur that requires you to break your scheduled appointment, we ask that you give a minimum of 24 hours notice for any appointment changes or cancellations, yet earlier notification is greatly appreciated. This gives other patients the opportunity to be scheduled in your place, and allows our practitioner's time to adjust their schedules. We ask that you arrive on time for your scheduled appointments. We reserve the right to charge for broken appointments when less than 24 hours notice is given. After 2 consecutive missed appointments, it is our policy to not reschedule you for any further appointments.

_____
Initial

ROYALTY AND PUBLISHING RIGHTS RELEASE FOR MODELS, PHOTOS, ETC.

I authorize the doctor or his designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs and to document my treatment. The doctor may use such items for obtaining insurance benefits, teaching, and publishing in professional literature, technique demonstration, marketing, and patient education without compensation or royalties.

_____
Initial

CONSENT TO RECEIVE TREATMENT

Upon diagnosis I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for complete recital of any possible complications.

_____
Initial

NOTICE OF PRIVACY POLICY

We care about your privacy and the privacy of your personal health information. By law we are required to maintain your privacy, and to give you notice of our privacy policies and practices. Our Privacy Policy is displayed in our office. It can also be viewed on our web site at www.mangandental.com and a printed copy is available upon request.

_____
Initial

ACKNOWLEDGEMENT AND SIGNATURE OF ACCEPTANCE

I have read, understand and agree to the above initialed policies.

Patient or Guardian: _____ Date: _____

Printed Name: _____ Relation: _____

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2016, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use,

else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a healthcare item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Official: Paul McNiel, Chief Compliance Officer
Telephone: 501.781.2777 Fax: 501.781.2778
Address: 610 President Clinton Ave, Little Rock AR 72201
E-mail: paul.mcniel@rockdentalbrands.com