

DATE: _____

Welcome

Thank you for selecting our dental healthcare team!
 We will strive to provide you with the best possible dental care.
 To help us meet all your dental healthcare needs, please fill out this form
 completely in ink. If you have any questions or need assistance, please ask us -
 we will be happy to help.

Burton M. Ogata, DMD

Soc. Sec.# _____

Patient Information (CONFIDENTIAL)

Cell Phone _____

Name _____ Birthdate _____ Home Phone _____
 Address _____ City _____ State _____ Zip _____
 Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
 Patient's or Parent's Employer _____ Work Phone _____
 Business Address _____ City _____ State _____ Zip _____
 Spouse or Parent's Name _____ Employer _____ Work Phone _____
 If Patient is a Student, Name of School / College _____ City _____ State _____
 Whom May We Thank for Referring You? _____
 Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
 Address _____ Home Phone _____
 Driver's License # _____ Birthdate _____ Financial Institution _____
 Employer _____ Work Phone _____
 Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Union or Local # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____
 How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
 Birthdate _____ Social Security # _____ Date Employed _____
 Name of Employer _____ Work Phone _____
 Address of Employer _____ City _____ State _____ Zip _____
 Insurance Company _____ Group # _____ Union or Local # _____
 Ins. Co. Address _____ City _____ State _____ Zip _____
 How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Form #1

NOTICE OF PRIVACY PRACTICES (DENTAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Form #2

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

#3

Burton M. Ogata DMD

SIGNATURE ON FILE

1. I hereby authorize payment of my dental insurance benefits to Burton M. Ogata DMD. I understand I am financially responsible for any charges whether or not paid by my insurance company.
2. If my insurance company designates co-payments and/or deductibles, I agree to pay them to Burton M. Ogata DMD.
3. I authorize Burton M. Ogata DMD to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.
4. I understand that, by signing this Consent form, I am giving my consent to your use & disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Name _____

Relationship to Patient: _____

Signature _____

Date _____