Please complete the following confidential patient registration forms using your keyboard and mouse.
Please then print, sign, and then mail, fax, or bring the forms with you to your next appointment. Our mailing address is: Michael J. Uzelac, DDS, 850 Marsh Street, Suite A, Valparaiso, IN 46385. Our fax number is (219) 548-8842.

# Welcome to Our Office!

Our Mission Is: To serve each patient and team member with integrity, respect and kindness. We are committed to working in collaboration with each individual to accomplish a comprehensive examination. We offer our patients the highest standards of excellence in preventative, restorative and esthetic services.

## Patient Information

Name: Mr. Mrs. Ms. ☐ ☐ ☐ _____ (*Last*) ____ (*MI*) _____ (*First*) Today's Date _____

What would you like us to call you? (preferred name) _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # (Home) _____ (Work) _____ (Cell) _____

E-mail Address _____

Social Security Number _____ Date of Birth _____

Whom may we contact in case of emergency?

Name _____ Phone # _____

Whom may we thank for referring you? _____

## Primary Insurance and/or Person Responsible for Payment

Name Mr. Mrs. Ms. ☐ ☐ ☐ _____ (*Last*) ____ (*MI*) _____ (*First*)

Street Address _____

If different from patient information:

City _____ State _____ Zip Code _____

Phone # (Home) _____ (Work) _____

Social Security Number _____ Date of Birth _____

Employer Name _____

## Spouse and/or Secondary Insurance

Name Mr. Mrs. Ms. ☐ ☐ ☐ _____ (*Last*) (*M/*) (*Firs t*)

Street Address _____

City _____ State _____ Zip Code _____

Phone # (Home) _____ (Work) _____

Social Security Number _____ Date of Birth _____

Employer Name _____

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, however, all charges for services and collection cost for untimely payments are ultimately my responsibility.

Signature (parent's if minor) X _____ Date _____

# Medical History

Name:_____ Date:_____

Address:_____

General Health: ☐ Excellent ☐ Good ☐ Fair Date of last physical _____

Physician's Name _____

Are you under current medical treatment? ☐ yes ☐ no

If yes, please explain: _____

Are you currently taking any medications or herbal supplements? ☐ yes ☐ no

If yes, please list medications and herbal supplements: _____

Do you have any allergies or adverse reaction to drugs? ☐ yes ☐ no

If yes please list: _____

Do you use any form of tobacco? ☐ yes ☐ no

Are you interested in quitting? ☐ yes ☐ no

Has a Physician ever informed you that you have or have had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Heart Murmur | ☐ yes | ☐ no | On Hormone Therapy | ☐ yes | ☐ no |
| Mitral Valve Prolapse | ☐ yes | ☐ no | On Birth Control Medication | ☐ yes | ☐ no |
| Other Heart Ailment | ☐ yes | ☐ no | Osteoporosis | ☐ yes | ☐ no |
| Artificial Joints | ☐ yes | ☐ no | Respiratory Disease | ☐ yes | ☐ no |
| HIV or Aids | ☐ yes | ☐ no | Intestinal Disease | ☐ yes | ☐ no |
| Hepatitis | ☐ yes | ☐ no | Cancer | ☐ yes | ☐ no |
| Pacemaker | ☐ yes | ☐ no | Chemo/Radiation Therapy | ☐ yes | ☐ no |
| High Blood Pressure | ☐ yes | ☐ no | Liver Disease | ☐ yes | ☐ no |
| Fainting Spells | ☐ yes | ☐ no | Kidney Disease | ☐ yes | ☐ no |
| Epilepsy | ☐ yes | ☐ no | Major Operations | ☐ yes | ☐ no |
| Head Injuries | ☐ yes | ☐ no | Diabetes | ☐ yes | ☐ no |
| Blood Disorder | ☐ yes | ☐ no | Stroke | ☐ yes | ☐ no |
| Latex Sensitivity | ☐ yes | ☐ no | Psychological/ Psychiatric Treatment | ☐ yes | ☐ no |
| Pregnant | ☐ yes | ☐ no | Drug/Alcohol Dependency | ☐ yes | ☐ no |
| Nursing | ☐ yes | ☐ no | Organ Transplant | ☐ yes | ☐ no |

Changes in medical history or medications:

_____

_____ Date _____ Patient's Initial _____

Changes in medical history or medications:

_____

_____ Date _____ Patient's Initial _____

Changes in medical history or medications:

_____

_____ Date _____ Patient's Initial _____

# Dental History

When was your last cleaning and examination? _____ Your last dental x-ray taken? _____

Who was your previous dentist? _____

What influenced you to change dentists? _____

What is your immediate dental concern? _____

Please check if you have, or ever had the following:

1. Unfavorable dental experiences ☐
2. Dental fears ☐
3. Orthodontic treatment (braces) ☐
   When? _____
4. Periodontal (gum) treatment ☐
   When? _____
5. Bleeding gums ☐
6. Part of your mouth is sensitive to temperature ☐
7. Dry mouth ☐
8. Do you have a sugar or soda pop habit? ☐
9. An unpleasant taste or odor in your mouth ☐
10. Viral infection or cold sores ☐
11. Jaw problems (temporomandibular joint) ☐
12. Difficulty opening your mouth widely ☐
13. Stiff or sore facial muscles ☐
14. Clench or grind your teeth ☐
15. Jaw clicking or popping? ☐
16. How often do you brush? _____
17. How often do you floss? _____
18. Wearing any oral appliances? _____

How important is it for you to keep the rest of your teeth for the rest of your life? (check one):

Not important 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Very Important

Please share with us any goals or ideas you may have regarding your oral health or smile:

_____

_____

To the best of my knowledge, the information above is correct. I realize that this office will provide insurance billing and assist with insurance benefits to the best of their knowledge, however, all charges for services and collection cost for untimely payments are ultimately my responsibility.

Signature (parent's if minor) X _____ Date _____

D•E•N•T•A•L
ARTS GROUP

# CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.

4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

# New Patient Insurance Registration Form

Understanding your insurance coverage can be challenging. Our goal is to assist you in maximizing your benefits. We care for patients from many different companies. Each company pays an insurance premium for specific coverage which fits the company budget. Each plan is slightly different with lower premium plans covering fewer services and lower fees for services. We encourage you to become familiar with your policy exclusions, deductibles and required co-payments.

**Our courtesy service to you includes:**

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronically filing your insurance for short turn around.
3. Researching your dental insurance plan to advise you of estimated benefits available to you.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

**Our expectations of you as the owner of the policy:**

1. Payment of fees not covered by your insurance plan at the time the service is delivered.
2. Understanding that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3. Taking responsibility for payment if the insurance company does not pay our office within 60 days.
4. Keeping our office informed of any changes in your insurance coverage or employment.

**To assist us in obtaining your benefits, Please sign the "assignment of benefits" below** to allow us to file your insurance claims. Also, please have your insurance card ready for us to copy for our file.

I hereby authorize Dr. Michael J. Uzelac to release to my insurance company, information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Dr. Michael J. Uzelac. I understand I am responsible for any unpaid balance.

_____ Date _____

Signature of Patient/Insured

**Notice of Privacy Practices**

**Protecting Your Confidential Health is Important to Us**

## Our Promise

Dear Patient:
It is our desire to communicate to you that we are taking seriously Federal law (HIPAA- Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your health information only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

## HOW YOUR HEALTH INFORMATION MAY BE USED TO PROVIDE TREATMENT

We will use your health information within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing your treatment.

**TO OBTAIN PAYMENT** - We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

**TO CONDUCT HEALTH CARE OPERATIONS** - Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

**IN PATIENT REMINDERS** - Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make and appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that maybe of interest to your or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email or texts (unless you tell us that you do not want to receive these reminders).

**TO BUSINESS ASSOCIATES** - We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

**NOTICE OF PRIVACY PRACTICES**

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

**As Required by Law** - We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

**Abuse or Neglect** - We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

**Public Health and National Security** - We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

**For Law Enforcement** - As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

**Family, Friends and Caregivers** - We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgement when sharing your health information only when it will be important to those participating in providing your care.

**Workers' Compensation Purposes** - We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

**Judicial and Administrative Proceedings** - We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

**Incidental Uses and Disclosures** - We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

**Health Oversight Activities** - We may disclose your health information to a government agency responsible for overseeing the heathcare system or health-related government benefit program.

**To Avert a Serious Threat to Health or Safety** - We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

Patient Acknowledgement

Patient's Name _____

Patient's Signature _____ Date _____