

JOINER FAMILY DENTISTRY

Jeffrey D. Joiner DDS • Abby J. Shannon DDS
123 Albany Ave. SE, Orange City

Welcome!

We are delighted that you have chosen Joiner Family Dentistry for your dental needs.

What a difference when you walk through the front door.....you will find a comfortable reception area, enjoyable atmosphere, as well as friendly staff members attentive to each individual's needs and well-being. State of the art equipment and sterilization techniques provide service of the highest quality. In addition to general dentistry, treatment in restorative and cosmetic dentistry, as well as CEREC[®] and Invisalign[®]. So, please let us know of anything to make your visit as pleasant an experience as possible.

Please download the New Patient Information, Medical / Dental History, and HIPAA Forms from this website. Bring completed forms, health related and insurance information, and insurance card with you to your appointment. Your appointment time is especially reserved for you and typically will last an hour.

Easy to locate at 123 Albany Ave. SE across from the Orange City Public Library, Joiner Family Dentistry has plenty of accessible parking. You will find a map on the new patient page of www.joinerdentistry.com.

Again, we are pleased to have you as a new patient and look forward to meeting you. If you have any questions or need help with anything, please feel free to give us a call (712) 737-3521

Sincerely,

Jeffrey D Joiner, DDS

Preferred Name _____

CONFIDENTIAL PATIENT INFORMATION

TODAYS DATE: ____/____/____

NAME Last _____ First _____ Middle _____ SEX: M F

STREET ADDRESS _____ City _____ State _____ Zip _____

MAILING ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTHDATE ____/____/____ AGE _____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____ MARRIED? YES NO

EMAIL ADDRESS _____

PREFERRED METHOD OF CONTACT (circle one) Home Phone Cell Phone Work Phone Email Text Messages Other _____

RESPONSIBLE PARTY INFORMATION

IF SAME AS PATIENT INFORMATION—SKIP THIS SECTION RELATIONSHIP TO PATIENT _____

NAME Last _____ First _____ Middle _____ SEX: M F

ADDRESS _____ City _____ State _____ Zip _____

SOCIAL SECURITY # _____ - _____ - _____ BIRTHDATE ____/____/____ AGE _____ DRIVERS LICENSE # _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

PHONE Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____ MARRIED? YES NO

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)	SECONDARY DENTAL INSURANCE INFORMATION
INSURED'S NAME _____	INSURED'S NAME _____
INSURANCE COMPANY _____	INSURANCE COMPANY _____
INS. CO. ADDRESS _____	INS. CO. ADDRESS _____
CITY _____ ST _____ ZIP _____	CITY _____ ST _____ ZIP _____
INSURED'S EMPLOYER _____	INSURED'S EMPLOYER _____
INSURED'S BIRTHDATE ____/____/____	INSURED'S BIRTHDATE ____/____/____
INSURED'S SSN# ____/____/____ ID# _____	INSURED'S SSN# ____/____/____ ID# _____
GROUP # _____ LOCAL # _____	GROUP # _____ LOCAL # _____
-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-	-PLEASE GIVE A COPY OF CARD TO THE RECEPTIONIST-

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE # (____) _____ - _____ WORK # (____) _____ - _____ CELL # (____) _____ - _____

CONSENT

The undersigned hereby attests that the above information is complete and accurate. I authorize the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a rebilling fee will be added to any overdue balance. I also acknowledge that I have been offered a copy of the offices Notice of Privacy Practices as required by law. I also understand that I can refuse parts of this consent by crossing out those sections that I disagree with but by so doing the Doctor may refuse treatment.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____/____/____

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Health and Dental History

Name _____

DENTAL HISTORY (CIRCLE YES OR NO AS NEEDED)		MEDICAL HISTORY (CIRCLE YES OR NO AS NEEDED)	
Are you having PROBLEMS or DISCOMFORT now?	Yes No	Do you have any current HEALTH PROBLEMS?	Yes No
PLEASE DESCRIBE		Are you under a PHYSICIAN'S CARE?	Yes No
		PLEASE DESCRIBE	
Do you wear DENTURES?	Yes No	What MEDICATIONS do you take and for what REASON do you take it:	
Have you had any PERIODONTAL (GUM) Treatment?	Yes No		
Do your gums BLEED or feel TENDER or IRRITATED?	Yes No		
Are your teeth SENSITIVE to hot, cold, sweets or pressure?	Yes No		
Are you aware of GRINDING or CLENCHING your teeth?	Yes No		
Have you worn BRACES? (ORTHODONTICS)	Yes No	Are you aware of any medications you are ALLERGIC to?	Yes No
If yes, do you wear a RETAINER?	Yes No	PLEASE LIST	
Would you like to change the APPEARANCE of your SMILE?	Yes No		
PLEASE DESCRIBE		Are you allergic to LATEX?	Yes No
		Are you PREGNANT?	Yes No
Are you APPREHENSIVE about dental treatment?	Yes No	Do you SMOKE?	Yes No
Have you ever been or interested in being SEDATED for dental treatment with drugs or NITROUS OXIDE (LAUGHING GAS)?	Yes No	Please circle any of the following conditions you have had or presently have:	
When was your last visit to a dentist and for what reason?		Prosthetic (Hip, Knee, etc.)	Heart Disease or Attack
		Mitral Valve Prolapse	Rheumatic Fever
		Diabetes	Kidney Problems
		High/Low Blood Pressure	Hepatitis
		AIDS or HIV Positive	Cancer/Chemotherapy
		Pacemaker	Drug/Alcohol Addiction
		Other: PLEASE LIST BELOW	
When was your last exam and cleaning?			
Please describe any other information you feel we should know:			
Have you been told to take an ANTIBIOTIC PREMEDICATION before any dental treatment by a dentist or physician?	Yes No	Do you take any herbal supplements? If yes please list below	
If yes, for what reason?			

Family Physician _____ City/State of Clinic _____

The undersigned hereby attests that the above information is complete and accurate.

PATIENT SIGNATURE (Parent if under 18) _____ DATE ____ / ____ / _____

Joiner Family Dentistry
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have offered a copy of this office's Notice of Privacy Practices.
{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) _____

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 (MM/DD/YR), 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.

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

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 \$0.25 for each page, \$15 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 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.

Joiner Family Dentistry HIPAA Officer

123 Albany Avenue SE • PO Box 198 • Orange City, IA 51041
www.joinerdentistry.com • dental@joinerdentistry.com
(712)737-3521 • (712)737-4891 fax