Crestview Hills Dental

232 Thomas More Parkway
Crestview Hills, KY 41017
859-331-8880

We are delighted to welcome you to our practice and are pleased that you chose us to serve your dental needs. We are serious about providing superior dental care at reasonable prices and proud of our dedication to our patients. Our goal is to help you feel and look your very best through excellent dental care.

To facilitate being seated at the time of your appointment, we would appreciate it if you would complete the enclosed Patient Information Forms before your arrival. Please remember to bring it with you at the time of your appointment.

If you have dental insurance, please remember to bring your insurance card.

Again, thank you for choosing our dental practice. We look forward to meeting you.

Sincerely,

Dr. Pete J. Rauen

Crestview Hills Dental – 232 Thomas More Parkway – Crestview Hills, KY 41017

Please fill in the following information. Your answers are for our records only and will be kept confidential subject to applicable laws.

General Information:

First Name: _____ Middle Name: _____ Last Name: _____

Gender: _____ DOB: ___/____/_____ Social Security Number: _____

Drivers License Number: _____

Home #: _____ Cell #: _____ Work #:_____

Mailing Address: _____

_____

_____

Emergency Contact: _____ Emergency Contact #: _____

Family Doctor: _____ Family Doctor #: _____

Occupation: _____

Employer:_____ Employer phone #: _____

Insurance Information:

Name of Insured:_____ Relationship to Insured:_____

Employer for the Policy Holder: _____

Insured SS# or Member ID: _____

Insurance Company: _____

Insurance Company Phone #: _____

Policy #: _____ Group #:_____

****

Signature:_____ Date: _____

Medical History

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

General Information:

First Name: _____ Last Name: _____ DOB: ___/____/_____

Gender: _____ Family Doctor: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Please list all prescriptions or over the counter medications that you are taking here including vitamins. (or you can provide a list and we will scan it).

_____

_____

Allergies: Are you allergic to any of the following?

____ Tylenol®/Acetaminophen ____ Acrylic ____ Aspirin ____ Codeine ____ Erythromycin

____ Food Allergies ____ Hay Fever/Seasonal ____ Ibuprofen/Advil®/Motrin® (NSAIDS)

____ Latex ____ Metals ____ Penicillin ____ Tetracycline ____ Other (please list below)

_____

Please elaborate on any reactions you have to any indicated allergies:

_____

_____

Do you have sleep apnea?	Yes	No
Have you ever reacted adversely to any medications or injections?	Yes	No
Have you had an orthopedic total joint (hip/knee/elbow/finger replacement)?	Yes	No
Have you ever taken FosaMax®, Boniva®, Actonel® or other medications containing bisphosphonates?	Yes	No
Do you use tobacco (smoking, snuff, chew, bidis)?	Yes	No
Are you wearing a nicotine patch?	Yes	No
Have you had a serious illness, been hospitalized in the last 5 years?	Yes	No

For Women:

Are you pregnant?	Yes	No
Taking birth control or hormone replacement?	Yes	No
Are you nursing?	Yes	

Conditions: (Please check all that apply)

- ☐ Abnormal/Excessive Bleeding
- ☐ AIDS or HIV Infection
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems/Respiratory Disease
- ☐ Cancer/Chemotherapy/Radiation Treatments
- ☐ Cardiovascular Disease
- ☐ Chest Pain Upon Exertion
- ☐ Chronic Pain
- ☐ Congestive Heart Failure
- ☐ Damaged Heart Valves
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells or Seizures
- ☐ Frequent Headaches
- ☐ G.E. Reflux/Persistent Heartburn
- ☐ Gastrointestinal Disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Hearing Difficulties
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Rhythm Disorder
- ☐ Hemophilia
- ☐ Hepatitis/Jaundice or Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
- ☐ Osteoporosis/Paget's Disease
- ☐ Other Congenital Heart Defects
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Recurrent Infections
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Rheumatoid Arthritis
- ☐ Severe Headaches/Migraines
- ☐ Severe or Rapid Weight Loss
- ☐ Sexually Transmitted Infection (STI)
- ☐ Stroke
- ☐ Systemic Lupus Erythematosus
- ☐ Thyroid Problems
- ☐ TMJ Disorder
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Other

If other please explain:

_____

_____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

_____ _____

Patient Signature Date

Crestview Hills Dental, Inc.
Pete J. Rauen D.M.D., Inc.

Acknowledgement of Receipt of Privacy Practices

Please fill out sections A and B only

SECTION A: The Patient.

Name: _____

Address: _____

Telephone: _____E-mail: _____

Social Security Number: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____Date _____

If a personal representative signs this authorization on behalf of the individual complete the following,

Personal Representative's Name _____

Relationship to Individual _____

Crestview Hills Dental, Inc.

Pete J. Rauen D.M.D., Inc.

Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

- All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.
- Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.
- A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.
- Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider.
- If there is dental insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.
- Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total.
- Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.
- A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.
- As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.
- Crestview Hills Dental will make every effort to accommodate my scheduling needs.

I have read, understand and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

_____	_____	_____
Patient Name	Date	Date of Birth

Crestview Hills Dental, Inc.

Pete J. Rauen D.M.D., Inc.

Office Policies

Our goal is to provide high quality care to our patients and respect their schedule as well. In fairness to other patients, and the office staff, we require advanced notice when changing or cancelling an appointment.

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us with advanced notice. We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once may result in a charge.

Patients who continue to no-show and/or cancel without notice may be dismissed from the practice and asked to find another dentist.

Any patient who is late may be considered a “no show” for their appointment and may need to be rescheduled.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

I have read, understand and agree to the above appointment policy.

_____	_____	_____
Patient Name	Date	Date of Birth

PRIVACY POLICY NOTICE

For Dr. Pete J. Rauen D.M.D., Inc.

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.

USES AND DISCLOSURES

Our office must provide you, the patient, a description and at least one example of the types of uses and disclosures that our office is permitted to make for the purposes of treatment, payment and health-care operations (all uses and disclosures, by the way that are permitted by the law without authorization by the patient).

Treatment - Our office will use and disclose your protected health information (PHI) for purposes of treatment, meaning the provision, coordination and management of your health care and related services. For instance, we will use and disclose your health information to coordinate benefits with a third-party payer, or for consultation between our office and a specialist if required for your care.

Payment - Our office will use and disclose the minimum necessary amount of your PHI to obtain payment for services rendered. For example, our office may share your treatment plan with your insurer to determine the coverage allowed by your benefits plan.

Health-care operations - Our office will use and disclose the minimum necessary amount of your PHI for health-care operations, such as business planning and development that involves conducting cost-management and planning related analyses related to managing and operating the entity, including formally development and administration, development or improvement of methods of payment or coverage policies. This section of our policy also must describe other purposes for which our office is permitted or required to use or disclose your PHI without your written authorization. No examples of each of the following instances is required in this notice.

Required by law - Our office may use and disclose your PHI only to the extent that such use is required by law.

Public health activities - Our office may use and disclose the minimum necessary amount of your PHI to appropriate public health authorities for reasons such as, but not limited to, preventing or controlling disease, injury or child abuse and neglect.

Reporting abuse, neglect or domestic violence - Our office may use and disclose the minimum necessary amount of your personal health information to the extent necessary to inform the appropriate government authority if we reasonably believe you to be a victim of abuse, neglect or domestic violence.

Health oversight activities - Our office may use and disclose the minimum necessary amount of your PHI to a health oversight agency for oversight activities authorized by law, such as for, but not limited in, audits.

Judicial and administrative proceedings - Our office may use and disclose the minimum necessary amount of your PHI in the course of any judicial or administrative proceeding if required by law to do so.

Law enforcement agencies - Our office may use or disclose the minimum necessary amount of your PHI to a law enforcement agency if required by law to do so.

Deceased patients - Our office may use or disclose the minimum necessary amount of your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death of another matter authorized by law, or to funeral directors to carry out their duties with respect to the deceased individual.

Research purposes - Our office may use and disclose the minimum necessary amount of your PHI for research purposes without your written authorization only if we have obtained one of the following: documented institutional review board or privacy board approval, either written or verbal representations that the information is to be used only to prepare a research protocol, either written or verbal representations that the information being sought is solely for research on the PHI of decedents, or a limited data use agreement.

Specialized government functions - If you are a member of the Armed forces, our office will use and disclose the minimum necessary amount of your PHI for military and veterans activities. Our office also will use and disclose the minimum necessary amount of your PHI for national security and intelligence activities, for protective services for the US. President and others. Our office also will use and disclose the minimum necessary amount of your PHI to a correctional institution or law enforcement agency if you are an inmate and that agency or institution indicates the information is necessary.

Safety - Our office may use or disclose the minimum necessary amount at your PHI if we believe doing so is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and other specific circumstances.

Workers' compensation proceedings - Our office may use or disclose the minimum necessary amount of your PHI as authorized by and to the extent necessary to comply with laws related to workers' compensation or similar programs.

Patient directory - Except when an objection is expressed by you, our office may use or disclose the minimum necessary amount of your PHI to maintain a directory of patients in the office. Said information includes your name, your location in the office, your condition described in general terms. We will inform you in advance of any such need and give you an opportunity to object, except in cases of emergencies when we must exercise professional judgment to determine whether use and disclosure of this information is in your best interest.

Friend, family and personal representatives - Our office will use and disclose the minimum necessary amount of your PHI that is directly relevant to the involvement of a family member, other relative, a close personal friend or someone else identified by you. Involvement could be in relation to care or payment for services. Our office also will use and disclose the minimum necessary amount of your PHI regarding your location, general condition or death to a family member, a personal representative of yours or another person responsible for the your care. Such uses and disclosures will be made only with your permission if you are present, unless you are incapacitated or there is an emergency circumstance where our office must exercise professional judgment.

Federal investigation - Our office may use and disclose the minimum necessary amount of your PHI for an investigation by the U.S. Department of Health and Human Services Secretary to determine if our office is in compliance with the

HIPAA privacy regulation that requires us to protect your individually identifiable health information.

Business associates - Our office may disclose the minimum necessary amount of your PHI to a business associate or allow the business associate to create or receive your PHI on our behalf only if the business associate has agreed in writing to appropriately safeguard the information.

Appointment reminders - Our office may use and disclose the minimum necessary amount of your PHI when contacting you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Marketing - Our office will obtain written authorization from you if we would like to use your PHI for marketing purposes, except for face-to-face communications or a promotional gift of nominal value provided to you while visiting this office. This office will inform you via the written authorization form if this office is to receive remuneration in connection with any marketing purpose. You have the right to revoke any authorizations as long as you do so in writing.

General authorization statement - For any other purposes not stated in this notice, our office will not use or disclose your PHI without your prior written authorization.

PATIENT'S RIGHTS

The patient - You have the right to inspect or obtain a copy *of your* PHI from our office. Our office requires you to submit such requests in writing to our privacy director. Our office must act on your request no later than 30 days after receipt of your request, unless the PHI requested is not maintained or accessible to our office on site, In the latter case, our office must respond to your request within 60 days of your request, and we must inform you of any such delay in writing within the initial 30-day time frame. If further delays are required, our *office* must may extend the time needed to respond to your request an additional 30 days provided that our office informs you in writing of the reasons for the delay and offers a date by which our office will respond to your request. Our office will provide you with access to your PHI to inspect or to obtain a copy, or both, in the form requested, if reasonable. If you agree to receive a summary of your PHI, our office will supply you with access to the summary.

Denial of access appeals - If our office denies your request for access to your PHI in whole or in part, we must provide you with access to any other PHI for which access is not denied. For the information that is denied, our office host inform you in writing of this denial within 30 days of the original request, and the statement must provide the basis for the denial. Reasons for denial may include the following circumstances: The doctor has determined, using his professional judgment, that access to the information is reasonably likely to endanger the life or physical safety of you or another person; the information requested makes reference to another person (unless the other person is a healthcare provider) and the doctor has determined, using his professional judgment, that granting your request is reasonably likely to cause substantial harm to this other person; and when the request for information is made by your personal representative and the doctor, using his professional judgment, has decided that the provision of the information to the personal representative is reasonably likely to cause substantial harm to you or another person. If access to your PHI is denied for these reasons, you have the right to have the denial reviewed by our Privacy Policy Committee, who has agreed to serve in this capacity for our office and cannot be involved in the original decision to deny access to your PHI. Our office will inform you in writing as to the decision by the committee within a reasonable period of time.

Restrictions - You have the right to request restrictions on certain uses and disclosures of your PHI, though our office is not required to grant such requests.

Confidential communications - You have the right to request, and our office must accommodate, reasonable requests to receive confidential communications of PHI from our office by alternative means or at alternative locations.

Accounting of disclosures - You have the right to receive an accounting of disclosures of your PHI made by our office for the six years prior to the date on which the accounting is requested. The following disclosures are exempted from this accounting: Disclosures to carry out treatment, payment and health-care operations; to you, the patient; for incidental uses or disclosures; disclosures made according to your written authorization; for the office patient directory; for national security; for correctional institutions; for a limited data set; or any disclosure that occurred prior to April 14, 2003. Our office will provide you with a written accounting that includes the disclosures required to be listed, such as those to business associates of our office. This accounting will include the date of disclosure, the name of the entity or person who received the PHI.

Electronic notice - You have the right to receive a paper form of this notice of privacy policies from our office upon request if this notice was received electronically.

Right to amend - You have the right to request our office amend your PHI. Our office, however, may deny such a request if we determine that the PHI was not created by our office, is not part of the designated record set, the information is not available for access to you, or the *current* information is accurate and complete. Amendment requests must he made in writing to our privacy director. Our office must act on such requests within 60 days of receipt of such requests. If we deny your request, we will inform you in writing within 60 days, indicating one of the reasons listed previously as the basis for the denial. If you do not submit a statement of disagreement, you may request that our office provide your request for amendment and the denial with any future disclosures of your PHI that is the subject of the amendment. If you submit a statement of disagreement (limited to 500 words.), our office may prepare a written rebuttal to your statement. We will provide you with a copy of the rebuttal.

Dental Office Duties

Our office is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Our office is required to abide by the terms of the notice currently in effect. Our office reserves the right to change the terms of this notice and to make the new notice provisions effective for all PMI that we maintain.

Complaints

Patients may file a complaint with our office and with the U.S. Department of Health and Human Services Secretary if they believe their privacy rights have been violated. Complaints must be filed within 180 days of when you knew or should have known that the alleged violation occurred. To do so, please request a complaint forth from our privacy director. Please be assured, patients who file complaints will not be retaliated against for doing so.

Contact

For more information about our office's privacy policies, contact the office Privacy Director at Telephone: 859-331-8880.

Effective Date

This notice for our practice is effective as of: April 14, 2003.