DUREN FAMILY DENTAL

ACQUAINTANCE FORM

NAME _____ PREFERRED NAME _____

ADDRESS _____
STREET CITY , STATE ZIP CODE

EMPLOYER _____ OCCUPATION _____

HOME PHONE ( ) _____ BUS. PHONE ( ) _____ CELL( ) _____

SOC. SEC. # _____ BIRTHDATE _____ SEX: MALE FEMALE

MARITAL: (circle) S M D W DRIVER'S LICENSE NUMBER _____

E-MAIL ADDRESS _____ E-MAIL CONFIRMATION YES____ NO___

IF PATIENT IS OVER 18 AND A STUDENT – NAME OF SCHOOL _____

WHO CAN WE THANK FOR REFERRING YOU? _____

PARENT OR GUARDIAN RESPONSIBLE FOR ACCOUNT

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____
STREET CITY, STATE ZIP CODE

EMPLOYER _____ OCCUPATION _____

HOME PHONE ( ) _____ BUS. PNONE ( ) _____ SOC. SEC. # _____

BIRTHDATE _____ SEX (M F) DRIVER'S LICENSE NUMBER _____

PRIMARY DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ EMPLOYER _____

SUBSCRIBER'S NAME _____ SOC. SEC. # _____

GROUP NUMBER _____ UNION OR LOCAL NUMBER _____

SUBSCRIBERS DATE OF BIRTH _____ RELATIONSHIP _____SELF _____SPOUSE _____ CHILD

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY _____ EMPLOYER _____

SUBSCRIBER'S NAME _____ SOC. SEC. # _____

GROUP NUMBER _____ UNION OR LOCAL NUMBER _____

SUBSCRIBERS DATE OF BIRTH _____ RELATIONSHIP _____SELF _____SPOUSE _____CHILD

DISCLOSURE UPDATES (12/2018)

Patient Information

Full Name: _____ Date of Birth: _____

Reminders and Confirmations
I would like to receive a postcard reminder for my dental cleaning appointments. YES NO

I wish to receive appointment confirmations in the following ways (a phone call will be made if no option is selected):

___ Call/Home ___ Call/Work ___ Call/Cell ___ Text ___ Email

Release of Information

You may give my clinical information to, or answer questions from (check all that apply):
___ Spouse ___ Parent ___ Child ___ Other _____

X Patient or Parent/Guardian Signature: _____ **Date:** _____

Appointments and Cancellations

_____ (Initial) I understand that if I am unable to keep a reserved appointment time, I must notify the office at least 24 hours in advance so that my reserved time may be made available to another patient. Patients who consistently cancel or miss appointments without notice, will not be rescheduled. I will also notify the office is I am going to be late for an appointment, and I may be asked to reschedule if it will make another patient wait. I also understand the office reserves the right to charge a minimum $50 cancellation/failed appointment fee.

Fees and Payments
We make every effort to keep down the cost of your dental treatment. An estimate of the charges for treatment, not including preventative appointments, will be given to you prior to the start of treatment. If you have dental insurance, we will be glad to submit the charges on your behalf. We do ask that you provide us your current dental insurance information and to notify the office of any dental insurance changes. ***It is your responsibility to know your plan benefits. Any deductible amount and patient portion not covered by insurance is due at the time of treatment, unless financial arrangements are made prior to the start of treatment.*** Finance charges on outstanding balances will incur interest of 1.5% per month. Failure to keep your account current may result in you, or anyone under that account, from being able to have additional treatment until the account balance is current. You may be seen for dental emergencies on a cash basis only.
I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE. I ALSO UNDERSTAND AND AGREE THAT IF I AM DEFAULT OF THIS AGREEMENT, MY BALANCE WILL BE SENT TO A COLLECTION AGENCY AND I WILL BE RESPONSIBLE FOR ALL COSTS INCURRED TO COLLECT MY DELINQUENT ACCOUNT. ***PLACEMENT OF YOUR ACCOUNT WITH AN OUTSIDE AGENCY WILL CAUSE US TO TERMINATE YOUR CARE IN OUR OFFICE.*** TERMINATION WILL ALSO OCCUR IF A BANKRUPTCY NOTICE IS RECEIVED ON ANY ACCOUNT BALANCE.

I hereby acknowledge that a copy of the office Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this notice.

X Patient or Parent/Guardian Signature: _____ **Date:** _____

DUREN FAMILY DENTAL
MEDICAL-DENTAL HISTORY

Patient Name: _____ Birthdate: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to Patient: _____

GENERAL HEALTH HISTORY

Are you in good health? YES NO

If NO, please explain: _____

Are you under a physician's care now? YES NO

If YES, please explain: _____

Physician Name: _____ Phone: _____

Are you taking any drugs or medications? YES NO

If YES, please list: _____

Are you sensitive or allergic to any of the following?

Aspirin	YES	NO	*Latex*	YES	NO
Codeine	YES	NO	*Metals*	YES	NO
Dental anesthetics (novacaine)	YES	NO	*Penicillin*	YES	NO
Erythromycin	YES	NO	*Tetracycline*	YES	NO
Jewelry	YES	NO	*Other:* _____		

Have you ever taken, or are you required to take, an antibiotic prior to dental treatment? YES NO

If YES, please list what kind: _____

Have you been hospitalized in the past two years? YES NO

If YES, please explain: _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
PLEASE ANSWER EACH QUESTION BY CIRCLING YES OR NO

Abnormal Bleeding	YES	NO	*Heart Murmur*	YES	NO
Alcohol Abuse	YES	NO	*Heart Surgery*	YES	NO
Allergies/Hayfever	YES	NO	*Hepatitis A, B, or C*	YES	NO
Anemia	YES	NO	*High Blood Pressure*	YES	NO
Arthritis	YES	NO	*Hip/Joint Replacement*	YES	NO
Artificial Heart Valve	YES	NO	*Kidney Problems*	YES	NO
Asthma	YES	NO	*Low Blood Pressure*	YES	NO
Blood Transfusion	YES	NO	*Medication Allergy*	YES	NO
Cancer/Chemotherapy	YES	NO	*Mitral Valve Prolapse*	YES	NO
Chew Tobacco	YES	NO	*Organ Transplant*	YES	NO
Congenital Heart Defect	YES	NO	*Pace Maker*	YES	NO
Diabetes	YES	NO	*Pre-Medication*	YES	NO
Drug/Substance Abuse	YES	NO	*Radiation Therapy*	YES	NO
Eating Disorder	YES	NO	*Rheumatic Fever*	YES	NO
Epilepsy	YES	NO	*Seizures*	YES	NO
Fainting Spells	YES	NO	*Smoke Cigarettes*	YES	NO
Fever Blisters	YES	NO	*Stroke*	YES	NO
HIV/AIDS	YES	NO	*Tuberculosis*	YES	NO
Heart Attack	YES	NO	*Ulcers*	YES	NO
Heart Disease	YES	NO	*Venereal Disease*	YES	NO

OTHER (please list): _____

PLEASE COMPLETE OTHER SIDE

Do you have recent unexplained weight loss or gain? YES NO
Do you wear contact lenses? YES NO
Do you have any disease, condition, or problem not listed? YES NO
If YES, please explain: _____

WOMEN: Are you pregnant? *(Number of weeks: _____)* YES NO
Are you nursing? YES NO
Are you taking birth control pills? YES NO

DENTAL HISTORY

Dental concern(s) at this moment: _____
Date of your last dental treatment: _____ Date of your last dental cleaning: _____

How often do you brush? _____ How often do you floss? _____

What do you like about your smile? _____
What would you like to improve about your smile? _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
PLEASE ANSWER EACH QUESTION BY CIRCLING YES OR NO

Pain in jaw joint	YES	NO	*Cold or canker sores*	YES	NO
Sore or sensitive teeth	YES	NO	*Unpleasant taste/odor*	YES	NO
Food collection between teeth	YES	NO	*Receding gums*	YES	NO
Smoke or chew tobacco	YES	NO	*Nail biting/other habits*	YES	NO
Periodontal/gum disease	YES	NO	*Dry mouth*	YES	NO
Parents with gum disease	YES	NO	*Grind or clench*	YES	NO
Spouse with gum disease	YES	NO	*Bleeding gums*	YES	NO

Have you ever had orthodontic care (braces)? YES NO
Are you interested in straightening your teeth? YES NO
Are you interested in whitening your teeth? YES NO

Do you use cough drops, hard candy, antacid tablets, or chew gum? YES NO
If YES, list type/frequency: _____

What types of beverages do you drink most often? _____ Frequency: _____

Do you prefer nitrous oxide (laughing gas) for your dental treatment? YES NO

Have you ever has any problems with dental treatment before? YES NO
If YES, please explain: _____
_____
_____

Please tell us anything else you think we should know about your dental health: _____
_____
_____
_____

PATIENT SIGNATURE: _____ **DATE:** _____
(OR PARENT SIGNATURE IF PATIENT IS A MINOR)

DOCTOR SIGNATURE: _____

CRAIG V. DUREN, D.D.S., P.A.
Patient Consent for Use and Disclosure of Protected Health Information

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 effect. This Notice takes effect April 14, 2003, 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.

USE AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose your 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 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 written 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 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 Patients 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 with your written authorizations.

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 and 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 authorize federal officials health required 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, emails 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 the Notice. We will charge you a reasonable cast-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 the Notice. If you request copies, we will charge you **$1.00** for each page, **$2.00** 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 request a list of instances in which we or our business associated disclosed for your health information for purposes, other that 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.

Restrictions: 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 Website or by electronic mail (email), you are entitled to receive this Notice in written from.

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 or your health information or have to us communicate with you to amend or restrict the use or disclosure of you 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.

Contact Officer: Craig V. Duren, D.D.S.
Address: 351 W. Nicollet Blvd. Burnsville, MN 55337
Email: info@durenfamilydental.biz
Telephone: 952-435-4142
Fax: 952-435-4187

Patient Name: _____ Signature Patient/Guardian: _____ Date: _____

CRAIG V. DUREN, D.D.S.
351 WEST NICOLLET BLVD.
(952) 435-4142

GENERAL CONSENT TO TREATMENT OF MINOR

TO: CRAIG V. DUREN, D.D.S. AND MEMBERS OF HIS STAFF

Patient Name: _____

Date of Birth: _____

I authorize **CRAIG V. DUREN, D.D.S. AND MEMBERS OF HIS STAFF,** to provide such regular dental care including cleaning, x-rays and fluoride to the minor as is necessary for the minor's health and best interests, or as in your judgment is advisable.

This authorization includes but is not limited to authorization for CRAIG V. DUREN, D.D.S to perform specific procedures including extractions and restorative procedures.

I authorize CRAIG V. DUREN, D.D.S. AND MEMBERS OF HIS STAFF to act on my behalf in case the minor is a victim of a major accident, injury or illness when immediate dental or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize CRAIG V. DUREN, D.D.S. AND MEMBERS OF HIS STAFF to take such action and give such consent on my behalf as their judgment dictates.

I acknowledge that CRAIG V. DUREN, D.D.S. deems it advisable that an authorized adult accompany the minor to the clinic for examination and treatment. I agree to cooperate by being present at all times possible or when requested.

Date: _____

Parent/Guardian:_____

Relationship to minor:_____

In case of emergency, please notify:

Name _____

Phone: Home: ( ) _____ Work: ( )_____

RELEASE OF DENTAL RECORDS

DUREN FAMILY DENTAL
CRAIG V. DUREN, D.D.S.
952-435-4142 952-435-4187(fax)
info@durenfamilydental.biz

Patient(s) name:_____

Patient(s) address:_____

_____

I hereby authorize my **previous dental clinic/dentist** to release my dental records to Duren Family Dental.

Dr. _____

ADDRESS _____

Phone Number _____

Email Address:_____

Please forward any or all dental records to:

Duren Family Dental
351 West Nicollet Blvd.
Burnsville, MN 55337 **Email: info@durenfamilydental.biz**

The information to be released:

_____X____Current Radiographs
_____Periodontal Probe Charting
_____Other _____

I understand that I may revoke this authorization at any time.

_____ _____
(Signature of patient, parent or guardian) (Date)