40 Creekview Ct.
Greenville SC 29615
864-676-0825
stackdental@gmail.com
www.stackdental.com

Patient Info

First Last MI Preferred Name

Address City State Zip Code

Home Phone # Cell Phone # Work # Email Address

SSN# DOB Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐

Responsible Party Relationship to You Phone # Current Patient Y or N ☐ ☐

Address if Different from above

Emergency Contact Phone # Relationship

How did you hear about us?

I understand that I am responsible for payment of serviced rendered and also responsible for paying any copayments and deductibles that my insurance does not cover at the time of service. I hereby authorize the release of any information, including the diagnosis and records of treatment or exams rendered to my insurance company.

Medical History

Patient Name **DOB** **Date Created**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	If yes
Are you under a physician's care now?	☐	☐	
Have you ever been hospitalized or had a major operation?	☐	☐	
Have you ever had a serious head or neck injury?	☐	☐	
Are you taking any medications, pills, or drugs?	☐	☐	
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐	☐	
Are you on a special diet?	☐	☐	
Do you use tobacco?	☐	☐	

Women are you…

Pregnant /trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives? ☐

Are you allergic to any of the following?

Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐

Sulfa Drugs ☐ Local Anesthetics ☐ Other

	Yes	No	If yes
Do you use controlled substances?	☐	☐	

Do you have, or have you had, any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	○	○	**Cortisone Medicine**	○	○	**Hemophilia**	○	○	**Radiation Treatments**	○	○
Alzheimer's Disease	○	○	**Diabetes**	○	○	**Hepatitis A**	○	○	**Anaphylaxis**	○	○
Drug Addiction	○	○	**Hepatitis B or C**	○	○	**Renal Dialysis**	○	○	**Anemia**	○	○
Herpes	○	○	**Rheumatic fever**	○	○	**Angina**	○	○	**Emphysema**	○	○
High Blood Pressure	○	○	**Rheumatism**	○	○	**Arthritis/Gout**	○	○	**Epilepsy or Seizures**	○	○
High Cholesterol	○	○	**Scarlet Fever**	○	○	**Artificial Heart Valve**	○	○	**Excessive Bleeding**	○	○
Hives or Rash	○	○	**Shingles**	○	○	**Artificial Joint**	○	○	**Excessive Thirst**	○	○
Hypoglycemia	○	○	**Sickle Cell Disease**	○	○	**Asthma**	○	○	**Fainting spells/Dizziness**	○	○
Sinus Trouble	○	○	**Kidney Problems**	○	○	**Blood Transfusion**	○	○	**Stomach/Intestinal Disease**	○	○
Liver Disease	○	○	**Stroke**	○	○	**Bruise Easily**	○	○	**Low Blood Pressure**	○	○
Swelling of Limbs	○	○	**Cancer**	○	○	**Glaucoma**	○	○	**Lung Disease**	○	○
Thyroid Disease	○	○	**Chemotherapy**	○	○	**Mitral Valve Prolapse**	○	○	**Chest Pains**	○	○
Heart Attack/Failure	○	○	**Osteoporosis**	○	○	**Tuberculosis**	○	○	**Cold Sores/Fever Blisters**	○	○
Heart Murmur	○	○	**Pain in Jaw Joints**	○	○	**Tumors or Growths**	○	○	**Congenital Heart Disorder**	○	○
Heart Trouble/Disease	○	○	**Yellow Jaundice**	○	○						

Have you ever had any serious illness not listed above?

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

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Our Office Financial Policy

Please Read the following financial policy below.

Payments for services in full are expected day of service unless arrangements are made prior to the appointment. Payments can be made with cash, check, Visa, Master Card, Discover, American Express and Care Credit. A $30 return check fee will be applied to your account if there are insufficient funds. If financial arrangements are required, talk to our front desk staff about payments plans.

If you have insurance, we will file your insurance claim with your insurance carrier at no cost to you. You can elect to pay for services rendered the day of service and have your benefits paid to you directly or you can elect to have your benefits paid to Jason A. Stack DMD PA. You may be asked to pay any estimated copay or deductible the day of service. Any balance after insurance has paid is the responsibility of the responsible party for the patient.

If you are unable to make your appointment, we require a 24 hour notice. If you do not show for your appointment, we reserve the right to charge you a $50 deposit fee to reschedule your appointment. If you fail your appointment after the deposit, there is no refund. The $50 can be applied to any balance that is left once you make your appointment. We also understand that there are sometimes circumstances that do not allow for a 24 hour cancellation notice. We will take into consideration those circumstances when applying the deposit to reschedule.

Printed Name of Legal Guardian

Signature of Patient/Legal Guardian

Dr. Jason Stack
40 Creekview Ct.
Greenville SC 29615
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HIPPA Authorization Form

It is the policy of Jason Stack DMD PA to contact you by leaving messages and/or speaking with family members. This information includes:

Appointment/prescription Refill Reminders
Preoperative and Postoperative information
Treatment options
Billing and Collection Information

If you do not want this information shared as described above, please submit a written request to our office.

Printed Name of Patient

Printed Name of Legal Guardian

Signature of Patient/Legal Guardian

I _____, have received a copy of the office's Privacy Practices.

Signature

Date

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 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 May 01, 2019, 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 the 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 Authorizations: 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 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, or 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 without your written authorization.

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 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 or 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, email messages or text messages).

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 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, we will charge you $0.50 for each page, $20 per hour for staff time to 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 below 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 associated 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 request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosures 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 on location, and provide satisfactory explanation how payments will be handled under the alternative means.

Amendment: You have the right to request that we amend your health information. (Your request must be 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, 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 to amend or restrict the use or disclosure of your health information or to have us communicate with you by 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 US Department of Health and Human Services. We will provide you with the address to file your complaint with the US 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 US Department of Health and Human Services.

Contact Officer: Allison Stack

Telephone: 864-676-0825 Fax: 864-676-9859