NEW PATIENT REGISTRATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME		
STREET ADDRESS	CITY		STATE	ZIP CODE
DATE OF BIRTH	AGE	BIRTHPLACE	SEX	MARITAL STATUS
			M F	S M D/W
SOCIAL SECURITY NUMBER	OCCUPATION	EMPLOYER	LOCATION OF EMPLOYMENT	
HOME PHONE (WITH AREA CODE)	CELL PHONE (WITH AREA CODE)	WORK PHONE (WITH AREA CODE)		
PREFERRED APPOINTMENT TIME/DAY	WERE YOU REFERRED TO OUR OFFICE? IF YES, BY WHOM?			
PERSON RESPONSIBLE FOR ACCOUNT	RELATIONSHIP TO PATIENT	ADDRESS	CITY	
STATE	ZIP CODE	INFORMATION PROVIDED BY:	DATE:	

DENTAL INSURANCE INFORMATION

DENTAL INSURANCE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME	SUBSCRIBER'S SOCIAL SECURITY NUMBER	

DENTAL HISTORY

Why are you seeking dental care at this time? _____

_____

Name/address of your previous dentist: _____

When was your last visit to the dentist? _____

When was the last time you had dental x-rays taken? _____

Check any of the following which you may have:

Jaw joint clicking or popping	☐	History of wearing braces / orthodontics	☐
Jaw pain	☐	Wisdom teeth removed / missing	☐
Clinching or grinding your teeth	☐	Loose teeth	☐
Frequent headaches	☐	Missing teeth	☐
Difficulty chewing	☐	Dry mouth	☐
Teeth that are sensitive to cold	☐	History of mouth sores or blisters	☐
Teeth that are sensitive to hot	☐	White or red spots in mouth	☐
Facial swelling	☐	Snoring	☐
Bleeding gums	☐	Sleep apnea	☐

Are you unhappy with the appearance of your teeth or crowns? _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Physician's name(s): _____

Address: _____ Phone: _____

What are you being treated for by your physician(s)? _____

_____

Please list any medications you currently take or are prescribed (including aspirin, herbs, or supplements):

_____

_____

Have you *ever* taken bisphosphanate medication including Fosamax, Zometa, Didronel, Boniva, or Aredia?

_____

Are you allergic to penicillin (including amoxicillin)? _____

If yes, please describe symptoms of the allergic reaction from penicillin: _____

Have you ever had any reactions to any other drugs or medicines, including, but not limited to local anesthetic or latex or rubber? _____

Have you ever had any surgery or operation? If so, please list and date. _____

_____

Women: Are you pregnant, or possibly pregnant? _____

Please review the list of medical conditions below and check the box for any condition you have now or may have had in the past.

Severe Head Injury	☐	Sleep Apnea	☐
Heart Attack	☐	Chronic Bronchitis	☐
Chest Pain	☐	Tuberculosis (TB)	☐
High Blood Pressure	☐	Arthritis	☐
Rheumatic Fever	☐	Artificial / Prosthetic Joint(s)	☐
Other Heart Conditions	☐	Fibromyalgia	☐
Anemia / Bleeding Problems	☐	Diabetes	☐
Severe Headaches	☐	Sexually Transmitted Disease	☐
Dizzy or Fainting Spells	☐	Herpetic Virus	☐
Stroke	☐	HIV Positive	☐
Epilepsy or Seizures	☐	Enlarged Lymph Nodes / Glands	☐
Psychiatric Treatment	☐	Tumor or Cancer	☐
Panic Attacks	☐	Radiation Therapy	☐
Hepatitis	☐	Chemotherapy	☐
Allergies or Sinus Problems	☐	Do You Use Tobacco?	☐
Emphysema	☐	Do You Use Injectable Drugs?	☐
Breathing Difficulties	☐	Do You Use Other Drugs?	☐

Please list any other medical condition(s) you have or may have had in the past not already listed:

_____

_____

JOSEPH A. LASHEEN, DMD
General Dentistry
Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Joseph A. Lasheen , DMD.

Joseph A. Lasheen, DMD *Legal Responsibilities:* As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced, and becomes effective 01/01/03. We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices 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 protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse of Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter

intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.
Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request. Your request to obtain access to your information must be in writing. You may obtain a *Protected Health Information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses, including copies and staff time. You may also request access by submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $1.00 for each page and $25.00 per hour for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.
Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years, but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.
Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. IF we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.
Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.
Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.
Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies; please contact us. If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring the issue forward. You may make a 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 at your request.
Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U. S. Department of Health and Human Services, we will not retaliate in any way. We are available to assist you with any questions, concerns or complaints.

I have read and understand the above privacy policies and procedures:

Date: ____/____/____ **Signed:** _____

Print Name: _____ **Phone:** _____

Address/City/State/ZIP: _____

JOSEPH A. LASHEEN, DMD

620 Perimeter Drive
Suite 200
Lexington, Kentucky 40517
(859) 268-2382

To: All Patients
From: Dr. Joe Lasheen
RE: Finance Charges
February 20, 2008

Effective this date, all accounts that have a balance of forty-five (45) days or older will be charged a finance charge of 1 ½% per month. This charge will be added after any applicable insurance claims have cleared.

This does not in any way reflect any problems we have had with your particular account. Rather, we feel it only fair to inform ALL patients of our new policy.

Joseph A. Lasheen, DMD

I acknowledge that any charges I incur with Dr. Lasheen , which remain unpaid after forty-five (45) days, will be assessed a finance charge of 1 ½% per month. I agree to assume the responsibility for this charge, if it becomes necessary to calculate it and add it to my balance.

Any account that remains unpaid and is turned over for legal collection action will be assessed a filing fee of $50.00, which will be added to my current account balance.

Signed _____ Date _____

Dental Claim Form

Check one:
- ☐ Dentist's pre-treatment estimate
- ☐ Dentist's statement of actual services

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last
2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other_____
3. Sex — m / f
4. Patient birth date — MM DD YYYY
5. If full time student — school / city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birth date — MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another dental plan? ☐ yes ☐ no — If yes, complete 12-a. Is patient covered by a medical plan? ☐ yes ☐ no
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of other employer(s)
14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber soc. sec. or I.D. number
14-c. Employee/subscriber birth date — MM DD YYYY
15. Relationship to patient — ☐ self ☐ parent ☐ spouse ☐ other_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ _____ Signed (Patient, or parent if minor) _____ Date

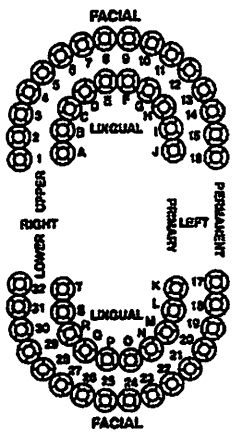
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ _____ Signed (Insured person) _____ Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted
City, State, Zip
18. Dentist Soc. Soc. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment — Office / Hosp. / ECF / Other
23. Radiographs or models enclosed? — No / Yes / How many?
24. Is treatment result of occupational illness or injury? — No / Yes — If yes, enter brief description and dates.
25. Is treatment result of auto accident? — No / Yes
26. Other accident? — No / Yes
27. If prosthesis, is this initial placement? — No / Yes — (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? — No / Yes — If services already commenced enter: Date appliances placed / Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee	For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ _____ Signed (Treating Dentist) _____ License Number _____ Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	