PLEASE PRINT

PATIENT Last Name _____ First _____ Initial _____

❑ Minor ❑ Single ❑ Married Birthdate: Month _____ Day _____ Year _____

Full time student? ❑ Yes ❑ No School _____

Address _____

City _____ State _____ Zip _____

Telephone (Hm) _____ (Wk) _____ (Cell) _____

E-mail _____

Employer _____ Soc. Sec. No. _____

* Dental Insurance Co. _____ Group No. _____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN PATIENT)

Last Name _____ First _____ Initial _____

Address _____ Birthdate _____

City _____ State _____ Zip _____

Telephone (Hm) _____ (Wk) _____ (Cell) _____

Employer _____ Soc. Sec. No. _____

* Dental Insurance Co. _____ Group No. _____

SPOUSE OF RESPONSIBLE PERSON (IF OTHER THAN PATIENT)

Last Name _____ First _____ Initial _____

Employer _____ Soc. Sec. No. _____

* Dental Insurance Co. _____ Group No. _____

* Please note that the patient is responsible for the payment of charges not covered by insurance.

LIST 1 PERSON OUTSIDE OF IMMEDIATE FAMILY TO CONTACT IN CASE OF EMERGENCY

Last Name _____ First _____ Initial _____

Address _____ Birthdate _____

City _____ State _____ Zip _____

Telephone (Hm) _____ (Wk) _____ (Cell) _____

Has any member of your family ever been treated in our office? ❑ Yes ❑ No

Whom may we thank for referring you to our office? _____

METHOD OF PAYMENT

Does responsible Party currently have an account with this office? ❑ Yes ❑ No

If **NO**, Please check on of the following:

❑ Payment in full at each appointment.

❑ Payment in full when billed. (Must complete credit application.)

❑ Monthly budget payments. (Must complete credit application.)

FINANCE CHARGE. If I do not pay the entire New Balance within 25 days of the monthly billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. The FINANCE CHARGE will be a periodic rate of 1.5% per month (or a minimum charge of $1.00 for a balance under $66.67), which is an ANNUAL PERCENTAGE RATE of 18% applied to the last month's balance. If I should default on my payment I promise to pay any legal interest on balance due along with any collection cost and reasonable attorney fees incurred in the collection of this account.

AUTHORIZATION

I hereby authorize Dr. Hurd to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and Medial History Form are correct to the best of my knowledge.

Signature _____ Date _____

❑ Adult Patient ❑ Parent ❑ Guardian

PATIENT INFORMATION FORM

PATIENT NAME _____ **DATE** _____

DENTAL HISTORY

Have you been having any specific problems? ❑ Yes ❑ No Describe:_____

Last dental visit? _____ Purpose:_____ Last complete exam: _____

Has fear of discomfort kept you from regular visits? ❑ Yes ❑ No

How would you describe your present dental health? ❑ Good ❑ Fair ❑ Poor

Do you think you have active dental disease: Decay? ❑ Yes ❑ No Gum Disease? ❑ Yes ❑ No

Home care: Brush? ❑ Yes ❑ No Floss? ❑ Yes ❑ No Water Jet? ❑ Yes ❑ No Other? _____

Do your gums ever bleed? ❑ Yes ❑ No How often? _____ Are you troubled with bad breath? ❑ Yes ❑ No

How do you feel about ever losing your teeth? _____

Have you had any unusual effects from previous dental treatment? ❑ Yes ❑ No Describe: _____

_____

MEDICAL HISTORY MONTH /DAY / YEAR MONTH /DAY / YEAR

Medical doctor's name:_____ Last physical exam:_____Birthdate: _____

(Women) Are you pregnant? ❑ Yes ❑ No How long?_____

Are you under a doctor's care now? ❑ Yes ❑ No If so, for what reason?_____

_____

Are you taking any RX medications, OTC, Supplements or Vitamins? ❑ Yes ❑ No Please list:_____

_____

Have you ever had any of the following?

❑ Yes	❑ No	A.I.D.S./ H.I.V.	❑ Yes	❑ No	Heart Trouble	❑ Yes	❑ No	Prolonged Bleeding
❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Psychiatric Treatment
❑ Yes	❑ No	Asthma	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Rheumatic Fever
❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Sinus Trouble
❑ Yes	❑ No	Drug or Alcohol Addiction	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Stroke
❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Joint Replacement	❑ Yes	❑ No	Thyroid
❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Kidney Trouble	❑ Other _____		

Have you had any other serious illness? ❑ Yes ❑ No Explain:_____

Have you been hospitalized in the last two years? ❑ Yes ❑ No Why?_____

Do you prefer Nitrous Oxide Sedation (tranquilizing air) during your dental treatment? ❑ Yes ❑ No

Cancer? ❑ Yes ❑ No

If yes, what type? _____

Allergic Reaction to antibiotics, narcotics, latex, food, other? ❑ Yes ❑ No

If yes, what? _____

Organ Transplant? ❑ Yes ❑ No

If yes, what type? _____

Cardiac Pacemaker? ❑ Yes ❑ No

Osteoporosis? ❑ Yes ❑ No

If yes, have you taken Bisphophonates? _____

Back Surgery? ❑ Yes ❑ No

If yes, what type? _____

Alcohol Use? ❑ Yes ❑ No

If yes, how much? _____

Tobacco (cigarette, smokeless, e-cig) ❑ Yes ❑ No

If yes, how much? _____

Drug Use (prescription or ill-legal) ❑ Yes ❑ No

If yes, what type? _____

Marijuana-medical or recreational? ❑ Yes ❑ No

Have you had Botox or Dermal Fillers? ❑ Yes ❑ No

DATE: _____ SIGNATURE:_____

Reviewed by: Doctor _____ Date_____ Blood Pressure: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kathy Paglione-Hurd, CDA, EFDA, Practice Administrator

Telephone: 719-544-7020 Fax: 719-544-5982

E-mail: office@drmarkhurd.com

Address: 3901 Outlook Blvd., Ste. C, Pueblo, CO 81008

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Mark D. Hurd., D.D.S.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

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

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ 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 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.

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 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 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 $0.75 for each page, $10.00 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 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 electronic mail (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.

Contact Officer: Gina Paglione-Davies Business Manager

Telephone: 719-544-7020 Fax: 719-544-5982

E-mail:

Address: 3901 Outlook Blvd., Suite C, Pueblo, CO 81008