HARTFORD COUNTY ORAL MAXILLOFACIAL & IMPLANT SURGERY, P.C. EAN R. JAMES, D.M.D., MD
259 Farmington Avenue - Bristol, CT 06010 2257 Silas Deane Highway – Rocky Hill, CT 06067

PATIENT REGISTRATION

NAME:_____
First *Middle* *Last*

ADDRESS:_____
Number *Street* *Apt #* *City* *State*
Zip Code

HOME TELEPHONE:_____ CELL PHONE: _____ PATIENT DATE OF BIRTH:_____

PATIENT'S SOCIAL SECURITY #:_____ EMAIL:_____

IF MINOR, PARENT OR GUARDIAN NAME:_____ DATE OF BIRTH:_____

MARITAL STATUS: (circle one) MARRIED SINGLE WIDOW SEPARATED DIVORCED

SPOUSE'S NAME:_____

GENERAL DENTIST: _____ PHYSICIAN (Medical Doctor):_____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHARMACY ADDRESS:_____

PHARMACY PHONE NUMBER: (_____) _____-_____

FINANCIAL AGREEMENT

1. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE PROPER AND ALL CURRENT INFORMATION.
2. I AM RESPONSIBLE FOR THE KNOWLEDGE OF MY INSURANCE PLAN AND WHAT IT COVERS.
3. I UNDERSTAND THAT MY INSURANCE IS BILLED AS A COURTESY TO ME AND THAT I WILL BE RESPONSIBLE FOR ALL BILLS THAT MY INSURANCE DOES NOT COVER.
4. I AGREE TO PAY ANY REMAINING BALANCE AFTER MY COPAY IS PAID AT THE TIME OF SERVICE.
5. I UNDERSTAND THAT THE AMOUNT COLLECTED AT THE TIME OF VISIT IS ONLY AN ESTIMATION OF WHAT MY INSURANCE COMPANY WILL COVER AND I WILL BE RESPONSIBLE FOR THE BILL AFTER THE INSURANCE COMPANY HAS PROCESSED MY CLAIMS.
6. I AUTHORIZE DIRECT PAYMENT TO HARTFORD COUNTY ORAL & MAXILLOFACIAL AND IMPLANT SURGERY AND/OR DR. EAN JAMES, DMD MD.
7. I AUTHORIZE AND AGREE THAT ANY AND ALL CLAIMS BE SUBMITTED ELECTRONICALLY OVER THE INTERNET.

PLEASE COMPLETE

OTHER SIDE…

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Privacy Notice

As a patient of Hartford County Oral Maxillofacial & Implants Surgery, P.C., we want to provide you with the best possible care and we want you to feel free to make full disclosure of information to the oral surgeon(s) so that effective treatment can be provided As required by the privacy provisions of Health Insurance Portability and Accountability Act of 1966 (HIPAA), Hartford County Oral Maxillofacial & Implants Surgery, P.C., is providing you, the patient or the patient's legal representative, with a copy of our Privacy Notice HTPPA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

The policy of Hartford County Oral Maxillofacial & Implants Surgery, P.C., is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information this policy applies to both current and former patients. Protected Health Information (PHI) is individually identifiable health and personal information and includes any information' obtained by Hartford County Oral Maxillofacial & Implants Surgery, P.C., m connection with providing healthcare treatment, obtaining payment and related healthcare operations This relates to past, present or future information that Hartford County Oral Maxillofacial & Implants Surgery, P.C., receives from you as our patient.

We will use this information to provide caring and quality medical care to you Examples of PHI include diagnosis, treatment and communications, both oral and written and including answering machines, voicemail and e-mail, used for follow-up and appointment scheduling and reminders As part of our standard healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most effective manner. For insurance carriers, your information will be used for claims submissions and to obtain payment for services provided we will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system We also maintain information about you in your medical chart Hartford County Oral Maxillofacial & Implants Surgery, P.C., limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amounts of information provided to that which is "minimally necessary" in order to carry out their work.

We do not disclose PHI to third parties for purposes other than treatment, payment or healthcare operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. Hartford County Oral Maxillofacial & Implants Surgery, P.C., will provide you with an Authorization Form that will need to be signed by you, the patient, or in case a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by us, the patient, or in the case of a minor, by his/her guardian at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers' Compensation purposes.

You have the right to request a review of your PHI to amend your records, and request restrictions on how your PHI is used and you may request an accounting of how your PHI has been disclosed Any requests for amendments or restrictions to the use of your PHI must be in writing. You have the right to request a copy of your medical record and Hartford County Oral Maxillofacial & Implants Surgery, P.C., will make every effort to provide you with your record within a reasonable amount of time and subject normal copying charges.

Name and phone numbers of persons we can share information with:

_____ or _____

I acknowledge that I have received the Privacy Notice of Hartford County Oral Maxillofacial & Implants Surgery, P.C.

Patient Signature: _____ Date: _____

PLEASE COMPLETE

OTHER SIDE…