SMILES OF WICHITA.COM
BENJAMIN LEE, DDS

ID: _____

Chart ID: _____

PATIENT REGISTRATION

Patient Name: _____ Preferred Name: _____
Last First Middle Initial

Responsible Party Information (If someone other than the patient)

Name: _____
Last First Middle Initial

Address: _____ Wk Phone: _____
Street City State Zip

Home or Cell Phone: _____ Birth Date: _____ Social Security #: _____

Email: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Sex: ◯ Male ◯ Female
Street City State Zip

Home phone: _____ Work phone: _____ Cell phone: _____

Birth Date: _____ Age: _____ Social Security #: _____ Drivers Lic: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Email: _____ ◯ I would like to receive correspondences via e-mail.

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired Student Status: ◯ Full Time ◯ Part Time

Medicaid ID _____ Employer ID _____ Carrier ID _____

Preferred Dentist _____ Preferred Pharmacy _____ Preferred Hygenist _____

Patient is: ◯ Policy Holder ◯ Responsible Party

Additional Comments

Primary Insurance Information

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Name of Insured: _____ DOB: _____ Social Security #: _____

Insurance company: _____ Group #: _____ Member ID: _____

Insc. Co. address: _____ Insc. Co. Phone: _____
Street City State Zip

Policy holder's employer: _____
Name Street City State Zip

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Name of Insured: _____ DOB: _____ Social Security #: _____

Insurance company: _____ Group #: _____ Member ID: _____

Insc. Co. address: _____ Insc. Co. Phone: _____
Street City State Zip

Policy holder's employer: _____
Name Street City State Zip

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

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BENJAMIN LEE, DDS

MEDICAL HISTORY

PATIENT NAME: _____ Birth Date: _____

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, ore medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes, please explain:	_____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain:	_____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain:	_____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, please explain:	_____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No		_____
Have you ever taken Fosamax, Boniva, Actonel or any other Medications containing bisphosphonates?	◯ Yes ◯ No		_____
Are you on a special diet?	◯ Yes ◯ No		_____
Do you use tobacco?	◯ Yes ◯ No		_____
Do you use controlled substances?	◯ Yes ◯ No		_____

Women: Are you...

Pregnant / Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex ◯ Local Anesthetics ◯ Sulfa Drugs

◯ Other If yes, please explain: _____

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

- ◯ AIDS/HIV+
- ◯ Alzheimer's Disease
- ◯ Anaphylaxis
- ◯ Anemia
- ◯ Angina
- ◯ Arthritis / Gout
- ◯ Artificial Heart Valve
- ◯ Artificial Joint
- ◯ Asthma
- ◯ Blood Disease
- ◯ Blood Transfusion
- ◯ Breathing Problem
- ◯ Bruise Easily
- ◯ Cancer
- ◯ Chemotherapy
- ◯ Chest Pains
- ◯ Cold Sores / Fever Blisters
- ◯ Congenital Heart Disorder
- ◯ Convulsions
- ◯ Cortisone Medicine
- ◯ Diabetes
- ◯ Drug Addiction
- ◯ Easily Winded
- ◯ Emphysema
- ◯ Epilepsy or Seizures
- ◯ Excessive Bleeding
- ◯ Excessive Thirst
- ◯ Fainting Spells / Dizziness
- ◯ Frequent Cough
- ◯ Frequent Diarrhea
- ◯ Frequent Headaches
- ◯ Genital Herpes
- ◯ Glaucoma
- ◯ Hay Fever
- ◯ Heart Attack / Failure
- ◯ Heart Murmur
- ◯ Heart Pace Maker
- ◯ Heart Trouble / Disease
- ◯ Hemophilia
- ◯ Hepatitis A
- ◯ Hepatitis B or C
- ◯ Herpes
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Hives or Rash
- ◯ Hypoglycemia
- ◯ Irregular Heartbeat
- ◯ Kidney Problems
- ◯ Leukemia
- ◯ Liver Disease
- ◯ Low Blood Pressure
- ◯ Lung Disease
- ◯ Mitral Valve Prolapse
- ◯ Osteoporosis
- ◯ Pain in Jaw Joints
- ◯ Parathyroid Disease
- ◯ Psychiatric Care
- ◯ Radiation Treatments
- ◯ Recent Weight Loss
- ◯ Renal Dialysis
- ◯ Rheumatic Fever
- ◯ Rheumatism
- ◯ Scarlet Fever
- ◯ Shingles
- ◯ Sickle Cell Disease
- ◯ Sinus Trouble
- ◯ Spina Bifida
- ◯ Stomach / Intestinal Disease
- ◯ Stroke
- ◯ Swelling of Limbs
- ◯ Thyroid Disease
- ◯ Tonsillitis
- ◯ Tuberculosis
- ◯ Tumors or Growths
- ◯ Ulcers
- ◯ Venereal Disease
- ◯ Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:

Other 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 medial status.

_____ _____

SIGNATURE OF PATIENT, PARENT or GUARDIAN DATE

SMILES OF WICHITA.COM
BENJAMIN LEE, DDS

FINANCIAL POLICY

I know or have been advised that I (or the named patient) am (is) exhibiting a condition warranting dental care and therefore voluntarily consent to such care, including routine diagnostic procedures and emergency dental treatment by Benjamin G. Lee D.D.S., P.A. his assistant and designees and the employees of said dental facility as is advisable in their judgment.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning examinations or treatments received in this dental facility.

I understand that any insurance deductible, co-payment, etc is due at time services are rendered. I hereby authorize payments of insurance benefits to Benjamin G. Lee D.D.S., P.A., and authorize the release of dental and insurance information necessary to facilitate dental care and payments therefore. I understand that Benjamin G. Lee D.D.S., P.A., will communicate with my insurance company to obtain payments but it is not a duty to secure or obtain insurance benefit payments. I also understand that the insurance company or payer of my dental benefits may pay less than the actual amount due and owing for services rendered and or decline payment and that I am responsible for payment of all amounts due for services rendered.

I understand that any unpaid balance is subject to interest rate at 29.99% per annum until paid in full and that I will be charged $30 service charge for returned checks. I understand that I am responsible for all costs of collections, including court costs and attorney fees, incurred by Benjamin G. Lee D.D.S., P.A. These remedies are not exclusive and Benjamin G. Lee D.D.S., P.A., does not waive any legal rights, interest, or remedy herein.

The terms herein supersede any existing or prior agreement relating to my financial responsibilities to pay for services rendered by Benjamin G. Lee D.D.S., P.A. The terms of this policy and agreement, and any action or claim related thereto, and governed by Kansas law and jurisdiction and venue shall be in Wichita, Sedgwick County.

I am of sound mind, legal age and free of duress. I understand that my representation as to solvency, insurance and or this agreement to pay is consideration for obtaining the services of Benjamin G. Lee D.D.S., P.A., and its doctors, agents designees and employees. By signing below, I certify that I have read and understood the above terms and agree to be bound thereby.

Patient's or Guardian's Signature: _____ Date: _____

Received By: _____ Position: _____

RELEASE

I hereby grant the doctors of Benjamin G. Lee D.D.S., P.A. to use my diagnostic treatment photographs, models and records for the purpose of display for scientific articles, seminars and presentations, and authorize release of any information concerning my (or my child's) healthcare, advise and treatment to another dentist.

Patient's or Guardian's Signature: _____ Date: _____

smilesofwichita.com
387 N Woodlawn St., Wichita, KS 67208
(316) 685-2309

SMILES OF WICHITA.COM
BENJAMIN LEE, DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

Treatment: We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your orthodontist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations, so the physician will know how you are responding to treatment. We will also provide your physician, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.

Payment: We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Health Care Operations: We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.

Business Associates: We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

Notification: We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Appointment Reminders / Health Benefits: We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

Funeral Directors and Coroners: We may disclose your health information to funeral directors, and to coroners or medical examiners, to carry out their duties consistent with applicable law.

Organ Procurement Organizations: Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Research: We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.

Fundraising: We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health Activities: As required by law, we may disclose your health information to public health, or legal authorities, charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities: We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.

Judicial and Administrative Proceedings: We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

Law Enforcement Purposes / Serious Threat to Health or Safety: We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.

Victims of Abuse, Neglect, and Domestic Violence: In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect, or domestic violence.

Essential Government Functions: We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes). The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information.

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

- If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.

- You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.

- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.

- If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.

- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.

- You have the right to be notified following a breach of your unsecured protected health information.

- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

Our Notice of Privacy Practice

By law we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

For More Information or to Report a Problem

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail. To file a complaint with the Secretary of HHS, send your complaint to our Privacy Officer.

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

Acknowledged By:_____ Date: _____

Signature of Patient or Personal Representative

Effective date of Notice:

smilesofwichita.com
387 N Woodlawn St., Wichita, KS 67208
(316) 685-2309

SMILES OF WICHITA.COM
BENJAMIN LEE, DDS

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize SMILES OF WICHITA to disclose certain protected health information about me to:

_____

(Name) (Address)

SMILES OF WICHITA is hereby authorized to disclose the following protected health information(specifically describe the information to be disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

☐ All Medical Records ☐ X-Rays ☐ Specific Information Listed Below:

_____

_____

_____

I understand that this request does not apply to: (1) certain health information that is not held in SMILES OF WICHITA'S medical records; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed for the following purpose:

_____

_____

This authorization will expire 90 days after the date of its execution or on _____ (name specific date or event), unless expressly revoked by me at an earlier time.

I understand that SMILES OF WICHITA may not condition my treatment on whether I sign this authorization.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this authorization at any time by delivering a revocation in writing to SMILES OF WICHITA at the address listed above, and if I revoke this authorization, it will have no effect on actions already taken by SMILES OF WICHITA in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient or Legal Guardian:_____ **Date:** _____

Patient Name: _____ **SS#:** _____

Address:_____ **City:**_____ **State:** _____ **Zip:** _____

DOB:_____ **Phone:** _____

Printed Name of Patient or Legal Guardian: _____

Witness: _____

PATIENT / GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION

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