Sonja L Maggard, DMD
Family, Cosmetic, & Implant Dentistry

121 Prosperous Place, Suite 12B
Lexington, KY 40509
(859) 263-1888

# Registration Form

**PATIENT INFORMATION:** (Please print)

Today's Date:____/____/_____

Name _____
Last First Initial

Nickname_____ Birthdate____/____/_____ SS#_____
(Please provide for insurance/identification purposes)

Whom may we thank for referring you? _____

Male____ Female____

Please circle one: Married Divorced Single Widowed

Address_____ City_____ State_____Zip_____
Cell Phone_____Home Phone_____ Work Phone _____
Email Address_____ Occupation _____
Employer_____ Employer Phone _____
Employer Address_____City_____ State_____Zip_____

**IN CASE OF AN EMERGENCY PLEASE CONTACT:**

Name_____ Relationship to Patient _____
Address_____ City_____ State_____Zip_____
Contact Number _____

**INSURANCE INFORMATION:**

Insur. Co. Name_____ Phone_____
Address _____
Subscriber's Name_____ Relationship to Patient_____
(If other than patient, please complete – if same as patient, write "same as above")
Subscriber's SS#_____ Birthdate____/____/_____
ID# on Card _____
Employer/Group Name_____ Group #_____
Employer Address_____City_____ State_____Zip_____

*I verify that the information completed above is accurate, and I understand that I am responsible for my account regardless of my insurance. I also understand that my insurance reflects only an agreement between my and my insurance company. Any balance remaining after insurance is the responsibility of the patient or guarantor. I understand that I may be charged a 1.5% finance charge per month for any delinquent balances on the account. I give my permission for the dentist and/or clinical team to take any necessary radiographs, study models and/or photographs in order to make a complete diagnosis of my dental needs. I authorize the dentist to release records as needed to my insurance company or third party to secure payment of benefits. I authorize my dental carrier to send payments directly to the dentist. Lastly, I authorize use of this signature on all insurance submissions.*

*Patient/Guardian Signature:_____ Date:____/____/_____*

*Doctor Signature:_____ Date:____/____/_____*

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# Getting to Know You

What are your goals for your teeth?_____
_____

Are you having pain?_____
_____

Where are you experiencing pain?_____
_____

How long have you been experiencing pain in this area?_____
_____

Have you whitened your teeth?_____
_____

Is the appearance of your teeth important?_____
_____

Are you strictly interested in good function with your teeth?_____
_____

Are you the personality that likes a lot of information, or the type that only wants to know the "nuts and bolts"?_____
_____

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# Cancellation Policy

When an appointment is made, a certain amount of time is reserved for just you! We do what we can to be here when you need us, and we kindly ask that you be here when expected. Due to numerous missed appointments, we have established the following:

The office of Dr. Sonja Maggard has instituted a policy in order to reduce the number of no show or missed appointments. We require a 72-hour notice for cancellation of any appointment that you will not be able to attend. If the notice is not given, you will be charged for the appointment and unable to reschedule until this bill has been paid in full. Although we do our best to call the day prior to your appointment, this is only done as a courtesy to you. It is only a reminder call.

Your appointment is considered confirmed the moment you make it.

Thank you for understanding.

*I have been made aware that a 72-hour notice must be given in order to cancel any appointment. If this notice is not given, I agree to pay the full amount and/or cost of the services for the time which was allotted for me.*

*Patient Signature:*_____ *Date:*____/____/_____

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# Patient Health History

If Patient is under the age of 18, please fill out the separate form, **Child History Form***, and continue to page 7, **Notice of Privacy Practices**.

(*Child Health History form is provided on the website as a separate PDF.)

Today's Date:____/____/_____

Patient Name _____

Last First Initial

Reason for today's visit:_____
Former Dentist:_____
Date of last dental visit:____/____/_____ Date of last dental x-rays:____/____/_____

**Dental History:** (Please circle all that apply)

**TMJ**
Headaches
Grinding/Clenching Teeth
Clicking or Popping of Jaw
Pain or Discomfort in Jaw Joint
Pain or Discomfort around Ear

**Perio**
Periodontal Disease (gum)
Bleeding Gums
Swollen Gums
Bad Breath
Dry Mouth
Mouth Breathing

**Habits**
Cigarette, Pipe, Cigar Smoking
Chewing Tobacco
Fingernail Biting

**Pathology**
Tooth Pain
Loose Teeth
Broken Fillings
Food Collection between Teeth
Chewing on one side of Mouth
Burning sensation of Tongue
Sores/Growths in Mouth
Blisters on Lips or Mouth
Lip or Cheek Biting
Sensitivity to Heat
Sensitivity to Cold
Sensitivity to Sweets
Sensitivity when Biting

**Oral Hygiene**
Problems with previous dental work
How often do you brush_____
How often do you floss_____
Type of bristles: Hard Medium Soft
Orthodontic Treatment
I like my smile
I dislike my smile

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**Past Medical History:** (Please circle all that apply)

| | | |
|---|---|---|
| Anemia | Coronary Artery Disease | Hyperthyroidism |
| Anxiety | Cortisone Treatments | Hypothyroidism |
| Arthritis | Cough (persistent/bloody) | Kidney Disease |
| Artificial Joints | Depression | Leukemia |
| Asthma | Diabetes | Liver Disease |
| Atrial Fibrillation | End-Stage Renal Disease | Low Blood Pressure |
| Back Problems | Epilepsy | Nervous Problems |
| Bleeding Abnormally | Fainting or Dizziness | Pacemaker |
| (with extractions or surgery) | GERD | Psychiatric Care |
| Blood Disease | Headaches | Radiation Therapy |
| Cancer | Heart Murmur | Respiratory Disease |
| Type_____ | Heart Problems | Seizures |
| Chemical Dependency | Hearing Loss | Skin Cancer |
| Chemotherapy | Hepatitis | Stroke |
| Circulatory Problems | Herpes | Tuberculosis (TB) |
| Congenital Heart Lesions | High Blood Pressure | Other_____ |
| COPD | HIV/AIDS | |

**Cautions:** (Please circle Yes or No)

| | | |
|---|---|---|
| Do you have a pacemaker? | Yes | No |
| Do you have a defibrillator? | Yes | No |
| Do you have an artificial heart valve? | Yes | No |
| Do you require antibiotics prior to dental procedures? | Yes | No |
| Do you have an allergy to red dye | Yes | No |
| Do you have an allergy to topical antibiotic ointments? | Yes | No |
| Are you taking blood thinners? | Yes | No |
| Are you pregnant, or currently trying to get pregnant? | Yes | No |
| Do you have an allergy to lidocaine? | Yes | No |
| Do you experience rapid heartbeat with epinephrine? | Yes | No |
| Do you get yeast infections with antibiotics? | Yes | No |
| Have you ever had problems with excessive bleeding? | Yes | No |

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Do you have problems with healing? Yes No

Do you have an allergy to Latex? Yes No

Have you had an artificial joint replacement? Yes No

If yes, when and what body locations?_____

**Medications:** (Please list all medications you are taking, and what they are for)

_____
_____
_____
_____

**Allergies:** (Please circle all that apply)

| | |
|---|---|
| Aspirin | Codeine |
| Barbiturates (sleeping pills) | Iodine |
| Local Anesthesia | Latex |
| Penicillin | No Allergies |
| Sulfa | Other_____ |

**Pharmacy of Choice:**_____
**Pharmacy Phone:**_____
**Pharmacy Location:**_____

**Patient Comments:**_____
_____

**Doctor Comments:**_____
_____
_____

*I certify that all medical information listed above is honest and accurate to the best of my knowledge.*

*Patient/Guardian Signature:_____ Date:____/____/_____*

*I, Dr. Sonja Maggard, have reviewed the above medical/dental history of said patient.*

*Doctor Signature:_____ Date:____/____/_____*

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# 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 04-14-03 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 of 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 of 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 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 of 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 institutions or law enforcement officials 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).

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## 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.___ for each page, $___ 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 and 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 04-14-03. If you request this accounting more than once a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restrictions:** 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.

**I have received Dr. Sonja L. Maggard's Notice of Privacy Practices.**

*Patient Signature:*_____ *Date:*____/____/_____

## 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 of disclosure of your health information or to have us communicate with you by alternative means or at alternate locations, you may complain to us using the contact information listed at the end of this Notice. You may also 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.

Telephone: (859) 263-1888
Fax: (859) 263-0566
Email: drsonjamaggard@windstream.net
Address: 121 Prosperous Place, Suite 12B
Lexington, KY 40509

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# Medical/Dental Information Release

*Please choose one of the following:*

**I DO** give Dr. Sonja Maggard's office permission to discuss my medical/dental condition with the following persons:

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

*Patient Signature:*_____ *Date:*____/____/_____

**OR**

**I DO NOT** give Dr. Sonja Maggard's office permission to discuss my medical/dental condition with anyone.

*Patient Signature:*_____ *Date:*____/____/_____

## HIPPA Acknowledgement

I,_____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice. I understand that this practice has an obligation to keep my records confidential, unless otherwise given permission by me to release information.

*Patient Signature:*_____ *Date:*____/____/_____

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# Office Policy and Consent Form

*Please remember, we are happy to serve you in a comfortable and professional atmosphere.*
*We do care, and we will provide you with the best quality of dental care available.*

## INSURANCE AND PAYMENT POLICIES

- Fees for Service at our office will be requested at the time of your visit.
- For Patients With Dental Insurance: We ask that you pay your deductible at your initial visit, and that your estimated portion be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances not covered by insurance benefits are your responsibility.
- All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatments.
- Please note for your convenience, we do accept VISA, MasterCard, Discover, American Express as well as checks and cash.

## OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. If you must change or miss an appointment, we do require a 72-hour notice. Noncompliance will result in a broken appointment charge of $35.00 or more, or no reappointment.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child under 18 years old is responsible to us for all fees incurred.
- A 1.5% finance charge will be assessed monthly on all overdue balances.
- If you have any questions regarding our policies and procedures, feel free to discuss them with us.

## CONSENT TO TREAT

*I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform diagnostic x-rays and treatment procedures, including local anesthesia and sedation deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment.*

*By law, Dr. Maggard must have x-rays before any dental treatment is rendered.*

*Patient/Parent/Guardian Signature:*_____ *Date:*____/____/_____

If patient is child, please print child's name_____