Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person responsible for account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address *(if different from patient)* _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address *(if different from patient)* _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

#80-243 R1

Appalachian Family Dentistry PLLC

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Our pledge regarding your protected health information (PHI):
We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by Appalachian Family Dentistry health care facilities. The purpose of this Notice is to explain who, what, when, where, and why your PHI may be used or disclose, and assist you in making informed decisions when authorizing anyone to use or disclose your PHI.

Your rights regarding your protected health information:
-To request in writing to the treatment area a restriction on the uses and disclosures of PHI as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require your authorization.
-To obtain a paper copy of this Notice and upon written request with the reasons supporting the request. We may deny your request if a) the record was not created by us; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.
-To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.
-To request in writing to the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter or telephone.
-To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be made in writing to the person/facility where you originally filed your authorization.

Our responsibilities:
We are required by law to:

-Maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.

-Abide by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your PHI, including information obtained prior to the change.

-Post notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

Contact for questions/complaints/requests:
Direct your questions, complaints, and requests made pursuant to this Notice to: Carly Tipton, D.M.D., Appalachian Family Dentistry, 1213 W G St Elizabethton, TN 37643 (423) 543-2755.

How we may use and disclose your PHI:
We may use and disclose your PHI for the following purposes:

-*Treatment*:

We may use and disclose your PHI to anyone involved in the provision of health care to you, including for example, physicians, nurse practitioners, nurses, and other medical professionals. We may also disclose your PHI to outside medical professionals and staff as deemed necessary for your health care.

-*Payment*:

We may use and disclose your PHI to billing and collection agencies, insurance companies and health plans to collect payment for our services.

-*Health Care Operations*:

We may use and disclose your PHI for our own health care operations. For example, we may use your PHI to assess your care in an effort to improve the quality of our service to you or to evaluate the skills, qualifications, and performance of our health care providers. In addition, our accountants, auditors, and attorneys may use your PHI to assist our compliance with the law.

-*Business Associates*:

There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.

-Individuals involved with your care:

We may disclose your PHI to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting the caregiver at he facility providing your care.

-Legally required disclosures and public health:

We may disclose PHI as required by the law, including to government officials to prevent or control disease, to report child, adult, or spouse abuse, to report reactions or problems with products, and to report births and deaths.

-Health Oversight Activities:

We may disclose your PHI to a federal or state oversight agency that is authorized to oversee our operations.

-Workers compensation:

We may disclose PHI for workers compensation or similar programs.

-Serious threats to health and safety:

We may disclose PHI if necessary to prevent or reduce the risk of a serious or imminent threat to the health or safety of an individual or the general public.

-Law enforcement and subpoenas:

We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.

-Inmates:

We may dispose your PHI to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or c) for the safety and security of the correctional facility.

-Information regarding decedents:

We may disclose PHI regarding a deceased person to 1)coroners and medical examiners to identify cause of death or other duties; 2) funeral directors for their required duties; or 3) to procurement organizations for purposes of organ and tissue donation.

-Research:

We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institution review board or privacy board has determined that obtaining authorization is not feasible and protocols are in pace to ensure the privacy of your health information. In all other situations, we may disclose PHI for research purposes with your authorization.

-Marketing and Fund Raising:

We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort.

-Appointment Reminders:

We may use and disclose your PHI to provide a reminder to you about an appointment.

-Treatment Alternatives:

We may use and disclose your PHI to contact you about treatment alternatives that may be of interest to you.

<u>Disclosures requiring authorization:</u>

All other disclosures of your PHI will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

<u>Changes to this notice:</u>

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all PHI we maintain by posting the revised Notice at our facilities, making copies of the revised Notice upon request, or posting the revised Notice to our website.

Appalachian Family Dentistry PLLC

Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, Appalachian Family Dentistry originates and maintains health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

-a basis for planning my care and treatment
-a means of communication among the many health professionals who contribute to my care
-a source of information for applying my diagnosis and medical treatment information to my bill
-a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
-and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Appalachian Family Dentistry's Notice of Privacy Practices gives a more complete description of how my health information may be used or disclosed. The Notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request as to how my health information is used and disclosed.

I understand that it is my responsibility to notify Appalachian Family Dentistry regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I have been provided with a Notice of Privacy Practices and have been given the opportunity to review this Notice.

_____

Signature of Patient or Legal Representative Date

_____

Witness Date

Appalachian Family Dentistry PLLC

Insurance and Payment Guarantee Form

The responsibility for payment of our services is the direct obligation of the patient, regardless of insurance. We will bill your dental insurance company for services on the date that treatment was rendered, provided you have given us complete and accurate information. We will bill insurances on your behalf for those companies that you provided, and those companies ONLY, on the day of service. **We will not accept and file insurances for treatment that has already been completed.** Be aware that dual insurance coverage does not always mean 100% coverage and/or full payment of your bill. Many companies have a dual benefit exclusion clause; therefore, you may have a balance due here.

Necessary information for proper filing of dental insurance includes: insured's name, date of birth, employer, often times the social security number (yes, many insurance companies still use the social security number as the ID#), member ID#, insurance company's name, your address, phone number, and group number. Please do not ask us to call your employer to get your personal insurance information for you. By law, they are not permitted under the HIPPA Act to give an outside party (us) any of your personal information.

Though we may have some knowledge of your coverage, the number of policies and dental plans number in the thousands. We are unable to keep current with all of them, as they change frequently. **Therefore, it is your responsibility to advise us of any insurance changes prior to treatment being rendered.** Changes normally occur annually, usually at the beginning of the new year. You and your employer have purchased this policy, and the final decisions regarding their obligation for payment of services is between you and the insurance carrier.

Also keep in mind just because you have $1000, $1500, or $2000 in benefits does not mean all services are covered. In most cases, the insurance company only covers a percentage of the procedure. Many insurance companies exclude some services and each contract is different.

I hereby guarantee the payment of the bill for services rendered. I further guarantee to pay, in addition to the other amounts herein provided, a 35% fee for collection fee, court costs, attorney fees, and any other expenses incurred for the purpose of collection.

_____

Responsible Party

_____

Date

_____

Witness

Appalachian Family Dentistry PLLC

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **DOB**: _____ **Date**: _____

Release of Information

[ ] I authorize the release of information including diagnosis, records, examinations rendered to me and claims information. This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____

[ ] Information is NOT to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call **[ ]** my home **[ ]** my work **[ ]** my cell number _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time) _____.

Signed: _____ **Date**: _____

Witness: _____ **Date**: _____