ToothMasters - New Patient Paperwork Form

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information

NAME:_____ **DATE:** _____

SSN/SIN:_____ **PATIENT'S SEX:** ○**F** ○**M**

HOME PHONE:_____ **EMAIL:**_____

CELL PHONE:_____

DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

YOU PREFER TO RECEIVE CALLS AT: ○Home ○Work ○Cell (**Select Appropriate Choice)**

Are you a student? ○ YES ○ NO

○ Minor ○Single ○Married ○Divorced ○Widowed ○Separated

SPOUSE NAME (If Married)**:**_____

Whom may we thank for referring you?_____

Responsible Party

NAME RESPONSIBLE FOR THIS ACCOUNT:_____

RELATIONSHIP TO PATIENT: ○Self ○Mother ○Father ○Guardian/Caretaker

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PHONE:_____ **DRIVER'S LICENSE #:**_____

DATE OF BIRTH:_____ **EMAIL:**_____

SSN/SIN Untitled:_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____

EMERGENCY CONTACT PHONE #:_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?

○Yes ○No

Insurance Information

NAME OF INSURED:_____ **DOB:**_____

EMPLOYER:_____

EMPLOYER ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

DATE EMPLOYED:_____ **EMPLOYER PHONE:**_____

UNION OR LOCAL #_____ **SSN/SIN Untitled:**_____

INSURANCE COMPANY:_____

INS COMPANY ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

GROUP #:_____ **POLICY/ID #:**_____

DO YOU HAVE ANY ADDITIONAL INSURANCE: ○Yes ○No

FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT.
PAYMENT SHOULD BE PAID IN FULL BEFORE EACH APPOINTMENT!!!
○Cash ○VISA ○MasterCard ○I do not wish to discuss the office's payment policy.

Patient Medical History

PATIENT NAME:_____

PHARMACY:_____ **PHONE:**_____

PHYSICIAN:_____ **PHONE:**_____

1. Are you currently under medical treatment? ○Yes ○No

2. Have you ever had any surgeries, procedures, or hospitalizations throughout your entire life?

○Yes ○No
If yes, please explain: _____

_____

3. Are you currently taking any medication(s) including non-prescription medicine?

○Yes ○No
If yes, what medication(s) are you taking?

Please list any medications you are currently taking. IF YOU HAVE A LIST WE CAN SCAN IT INTO YOUR CHART.

_____

_____

4. Have you ever taken Fen-Phen/Redux?

○Yes ○No

5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?

○Yes ○No

6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?

○Yes ○No

7. Do you use tobacco?

○Yes ○No

8. Do you use controlled substances?

○Yes ○No

9. Check all current and past conditions:

☐High Blood Pressure	☐Heart Attack	☐Rheumatic Fever
☐Swollen Ankles	☐Fainting / Seizures	☐Asthma
☐Low Blood Pressure	☐Epilepsy / Convulsions	☐Leukemia
☐Diabetes	☐Kidney Diseases	☐AIDS or HIV Infection
☐Thyroid Problem	☐Heart Disease	☐Cardiac Pacemaker
☐Heart Murmur	☐Angina	☐Frequently Tired
☐Anemia	☐Emphysema	☐Cancer
☐Arthritis	☐Joint Replacement or Implant	☐Hepatitis / Jaundice
☐Sexually Transmitted Disease	☐Stomach Troubles / Ulcers	☐Chest Pains
☐Easily Winded	☐Stroke	☐Hay Fever / Allergies
☐Tuberculosis	☐Radiation Therapy	☐Glaucoma
☐Recent Weight Loss	☐Liver Disease	☐Heart Trouble
☐Respiratory Problems	☐Mitral Valve Prolapse	
☐_____		

10. Are you wearing contact lenses?

○Yes ○No

11. Are you allergic to or have you had any reactions to the following? Select all that apply.

☐Local Anesthetics (e.g. Novocain)	☐Penicillin or any other Antibiotics
☐Sulfa Drugs	☐Barbiturates
☐Sedatives	☐Iodine
☐Aspirin	☐Any Metals (e.g. nickel, mercury, etc.)
☐Latex Rubber	☐_____

12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?
○Yes ○No

13. Woman Only
a) Are you pregnant or think you may be pregnant?

○Yes ○No

b) Are you nursing?

○Yes ○No

c) Are you taking oral contraceptives?

○Yes ○No

Patient Dental History

NAME OF PREVIOUS DENTIST: _____

LOCATION:_____ **DATE OF LAST EXAM:**_____

Check all that apply to you or your immediate family:

☐Asthma / Lung Problems	☐Cancer	☐Cardiac Disease
☐Diabetes	☐History of Back Pain	☐Hypertension
☐Psychiatric Disorders	☐Seizure Disorder	☐Stroke

1. Do your gums bleed while brushing or flossing? ○Yes ○No

2. Are your teeth sensitive to hot or cold liquids/foods? ○Yes ○No

3. Are your teeth sensitive to sweet or sour liquids/foods? ○Yes ○No

4. Do you feel pain in any of your teeth? ○Yes ○No

5. Do you have any sores or lumps in or near your mouth? ○Yes ○No

6. Have you had any head, neck, or jaw injuries? ○Yes ○No

7. Have you ever experienced any of the following problems with your jaw? Select all that apply.

☐Clicking ☐Pain (joint, ear, side of face) ☐Difficulty in opening or closing ☐Difficulty in chewing

8. Do you have frequent headaches? ○Yes ○No

9. Do you clench or grind your teeth? ○Yes ○No

10. Do you bite your lips or cheeks frequently? ○Yes ○No

11. Have you ever had any difficult extractions in the past? ○Yes ○No

12.Have you ever had any prolonged bleeding following extractions? ○Yes ○No

13. Have you had any orthodontic treatment? ○Yes ○No

14. Do you wear dentures or partials? ○Yes ○No

15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ○Yes ○No

16. Do you like your smile? ○Yes ○No

17. What type of consultation do you need? ○Regular ○Denture ○Not Sure

Authorization and Release

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

This office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

SIGNATURE OF PATIENT (parent/guardian if minor):_____ **DATE:** _____

Financial Responsibility Agreement/Insurance

Assignment/HIPAA Acknowledgement

Due to the increased cost for billing, patient's failure to fulfill their financial obligations, and other changes in healthcare regulation, it is necessary for our office to implement the policies below. If you have any questions or concerns regarding these policies, you may contact our practice administrator.

CO-PAYMENTS: Co-payments are required when services are rendered. **BALANCES:** All balances must be paid in full before seeing the physician.

APPOINTMENTS: Please help us serve you and all our patients best by keeping your scheduled appointment. If it is necessary to reschedule your appointment, please give 24-hour notice to avoid a $30 fee.

OBTAINING MEDICAL HISTORY: To the extent permitted by applicable law, I authorize this dental practice to collect information about my prescription history from my pharmacy and insurers and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/HIV and medicines used to treat mental health issues.

FMLA/RECORDS: Our office will be charging a $10.00 fee for filling out FMLA forms and for copying records or x-rays. This charge is not reimbursed by your insurance. Payment can either be made at the time forms are dropped off or picked up.

CELL PHONE CALLS/TEXT MESSAGES: You agree, in order for us to service your account or to collect monies you may owe, ToothMasters, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other State.

NO CHECKS

WE ACCEPT VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARE CREDIT OR CASH. (3% CREDIT CARD PROCESSING FEE WILL BE ADDED TO YOUR TOTAL)

I fully understand my financial responsibility for services rendered at ToothMasters and understand that failure to comply with these policies will result in having to reschedule any appointments until I can fulfill my responsibility.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Price all insurance benefits, if any, otherwise payable to me for services rendered. I understand that lam financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under HIPAA. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers; the day-to-day healthcare operations of your practice. I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of Patient or Authorized Representative:

_____

Tooth Masters
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.

Tooth Masters, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 05/23/2016. You may access or obtain a copy according to the following options: 1) our website at www.toothmasters.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We
Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.
A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.
B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.
C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

<u>Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object:</u>
We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:
D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:
E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.
F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.
G) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18) requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:
A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.
B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).
C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.
D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.
E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.
F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.
G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.
H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:
Tooth Masters
139 Aliant Parkway
Alexander City, Alabama 35010
TEL: (256) 329-8401
info@toothmasters.com

You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the office's Notice of Privacy Practices. Tooth Masters provides this form to comply with the HIPAA requirements. Please review the Notice of Privacy Practices before signing this document.

By signing this form, you acknowledge that we may use and disclose your protected health information for treatment, payment, and healthcare operations. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, and healthcare operations.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Print Name of Patient or Legally Authorized Representative Legal Relationship to Patient

I give permission for Tooth Masters to:

□ Call/leave message at my home telephone number: _____

□ Call/leave message/text on my mobile number: _____

□ Call/leave message on my work number: _____

□ Send me an unencrypted email: _____

□ Other:

_____

I give permission for you to speak with these individuals about my care:
(Note: Please notify us if you wish to make a change in the future.)

Name	Relationship	Phone Number

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ Office Use Only ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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

□ Patient/Representative refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please Specify): _____

Staff Initials: _____

Consent for Treatment

PATIENT'S NAME:_____ DATE:_____

I have provided as accurate and complete a medical and personal history as possible including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I permit the recommended diagnostic procedures to be completed.

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I acknowledge that no guarantees, warrantees, or representations have been made to me concerning the results of treatment.

I consent to the injection and administration of local anesthetics. I understand that there is an element of risk with the injection of any injectable agent. These risks include, but are not limited to: adverse drug reactions, allergic reactions, cardiac arrest (heart stops beating), tachycardia (very fast heartbeat), swelling, bruising, pain, transient or permanent nerve damage (numb lip, etc.), asthmatic reactions (difficulty breathing), needle tract infection and other unspecified injuries.

INFORMED CONSENT FOR RADIOGRAPHS (X-RAYS)

Benefits and alternative treatments

- A more complete diagnosis because we can see problems between the teeth.
- A more complete diagnosis of periodontal disease by letting the dentist see bone loss on the x-ray.
- A more complete diagnosis of pulpal health by being able to see roots of teeth.
- Alternatives: NONE

Common Risks

- Exposure to x-ray radiation.

Consequences of not performing treatment

Diagnosis of dental problems between the teeth cannot be made resulting in undetected tooth decay. Undetected tooth decay will eventually lead to pulpal infection which will require root canal treatment or extraction (loss of tooth) to alleviate infection and/or pain. Diagnosis of periodontal disease is incomplete because it is difficult to access bone loss by periodontal probing alone.

I wish to proceed with radiographs:

PATIENT'S NAME:_____ DATE:_____

SIGNATURE:_____

NAME OF PATIENT'S PARENT OR GUARDIAN:_____

PATIENT'S PARENT OR GUARDIAN SIGNATURE:_____

Broken Appointment Policy

Your scheduled appointment is reserved specifically for you. It is extremely important that all patients honor their reserved dental appointment. Failure to do so deprives other patients from receiving dental care in a timely fashion.

- We reserve the right to charge $30 for appointments that are cancelled or broken without 24 hours' notice.
- Any broken appointment charges will need to be taken care of before you are able to reschedule for another appointment.
- We understand that emergencies arise unexpectedly, and we will carefully assess each instance before applying and broken appointment fees.
- The charge associated with our policy is to be paid within 30 days to prevent collection procedures.
- Multiple cancellations and broken appointments may result in dismissal from ToothMasters.

I, the undersigned, have read and understand the broken appointment policy. I agree to any fees that are charged, should I fail to keep an appointment.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN:_____

DATE:_____

PATIENT CHECK LIST BEFORE RETURNING PAPERWORK

- ☐ ALL PAGES OF THIS PAPERWORK HAVE BEEN COMPLETED

- ☐ COPY OF DRIVERS LICENSE OR GOVERNMENT ISSUED ID

- ☐ COPY OF INSURANCE CARD FRONT AND BACK IF APPLICABLE

- ☐ UPDATED MEDICATION LIST IF APPLICABLE