



PATIENT INFORMATION

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____
Birthdate _____ Age _____ Sex Male Female I prefer to be called _____
S.S.N. / S.I.N. _____ Home Phone _____ Cell _____
Email Address _____
Patient Address _____
City _____ State _____ Zip _____
Sports/Hobbies _____
Patient's Present Weight _____ lbs Height _____ ft. _____ in.
Custodial Parent(s) or Guardian(s) _____
Phone (if different than patient's) _____ Cell _____
Address (if different than patient's) _____
City _____ State _____ Zip _____

PREVIOUS DENTIST INFORMATION

Name of Patient's Dentist _____ Phone _____
Dentist's Address _____
City _____ State _____ Zip _____
Date Last Seen _____ Reason _____
Name of Patient's Physician(s) _____
Phone Number(s) _____
Primary Physician's Address _____
City _____ State _____ Zip _____
Date Last Seen _____ Reason _____

RESPONSIBLE PARTY INFORMATION *(If Not Patient)*

Last Name _____ First Name _____ Middle Initial _____
Address (if different than patient's) _____
City _____ State _____ Zip _____
Phone (if different than patient's) _____ S.S.N. / S.I.N. _____
Employer _____ Years with Employer _____

DENTAL INSURANCE INFORMATION

Coverage for Dental Treatment? Yes No Coverage for Orthodontic Treatment? Yes No
Primary Policy Holder's Name _____ S.S.N. / S.I.N. _____
Birth Date _____ Employed By _____
Dental Insurance Company _____ Group Number _____
Secondary Policy Holder's Name _____ S.S.N. / S.I.N. _____
Birth Date _____ Employed By _____
Dental Insurance Company _____ Group Number _____
Medical Insurance Company _____ Group Number _____



MEDICAL HISTORY

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, or 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 If yes, what? _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, what? _____
- Are you on a special diet? Yes No If yes, what? _____
- Do you use tobacco? Yes No If yes, what? _____
- Do you use controlled substances? Yes No If yes, what? _____

Are you a woman who is... Pregnant/Trying to get pregnant Nursing Taking oral contraceptives

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Other _____
- Metal Latex Sulfa Drugs Local Anesthetics No Known Allergies

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

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

Have you ever had any serious illness not listed above? Yes No If yes, _____

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 medical status.

Signature of Patient, Parent or Guardian _____

Date _____



NOTICE OF PRIVACY PRACTICES

Effective date: December 1, 2018

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.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with **Definition Dental Studio**. This information is called “protected health information” (i.e., name, address, phone, etc.) that may identify you and relate you to your past, present or future physical or mental health condition and related healthcare services.

Definition Dental Studio is required by law to maintain the privacy of protected health information and to follow the terms of this notice. This notice describes certain patient rights and how we use and disclose your protected health information to provide your treatment, obtain payment for services, receive and manage our health care operations and for other purposes that are permitted or required by law.

This notice has been drafted to be consistent with what is known as the Privacy Rule (45 CFR Parts 160 and 164) and any of the terms not defined in this notice should have the same meaning as they have in the Privacy Rule. We are also required to comply with any federal or state laws that impose stricter standards than the uses and disclosures described in this notice.

We reserve the right to change the terms of our notice, at any time. New versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised notice of privacy practices.

YOUR RIGHTS UNDER THE PRIVACY RULE

You have the following rights regarding protected health information that we maintain about you. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this notice of privacy practices by requesting a copy from our front desk at **615-784-3394**. You have the right to obtain a paper copy of this notice at any time, even if you have already received an electronic notice.

You have the right to authorize other uses and disclosures. This means we will not use or disclose your protected health information other than as specified in this notice, unless you authorize the use or disclosure in writing. You may revoke an authorization at any time, in writing, except to the extent that our office has taken an action in reliance on the use or disclosure indicated in the authorization.

To exercise any of the rights below, you must submit a written request to our privacy manager at the address listed above.

You have the right to designate a personal representative. This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is used to make decisions about you, such as health and billing records. Your request may be denied for certain reasons permitted by applicable law.

You have the right to request a restriction of your protected health information. This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. We may deny your request for a restriction.

You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted and specify information on how payment will be handled.

You may have the right to have us amend your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.



NOTICE OF PRIVACY PRACTICES

You have the right to request an accounting of certain disclosures. This means that you may request a listing of disclosures of protected health information that we have made, except for disclosures made for purposes of treatment, payment, health care operations or for other purposes excluded from the accounting requirement. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our front desk of your complaint at 615-784-3394. You will not be penalized for filing a complaint.

HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected information, consistent with the requirements of applicable law. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment – We may use protected health information to provide you with health care treatment or services. We may disclose your protected health information for purposes of treatment, which includes providing, coordinating, or managing your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions.

For Payment – We may use or disclose your protected health information to obtain payment for our services. This may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services providing to you for dental necessity, and undertaking utilization review activities.

For Health Care Operations – We may use or disclose your protected health information in order to support the business activities of our practice. Health care operations include, but are not limited to, business planning and development, quality assessment and improvement, dental review arranging for legal services and auditing functions. It also includes education, provider credentialing, certification and underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievances procedures, due diligence in connection with the sale or transfer of assets and creating de-identified information. We may also call you by name in the waiting room when your dentist is ready to see you.

For Treatment Alternatives and Appointment Reminders – We may use or disclose your protected health information to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. We may contact you to provide information about health related benefits and services offered by our office.

To Others Involved in Your Dental Care and for Disaster Relief Purposes – With your consent, we may disclose to a member of your family, a relative, or close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your dental care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. Further, we may use or disclose your protected health information to disaster relief agencies so they may assist in notifying those involved in your care of your location and general condition. If you are not present or able to agree or object in these rules or disclosures, then we may, using professional judgment, determine whether the disclosure is in the best interest. In this case, only the protected health information that is relevant to your dental care will be disclosed.

As Required by Law – We may use or disclose your protected health information to the extent that law requires the use or disclosure, including when disclosure is required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Privacy Rule.

For Public Health – We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases – We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.



NOTICE OF PRIVACY PRACTICES

For Health Oversight – We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Case of Abuse or Neglect – We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information.

For Legal Proceedings – We may disclose protected health information in the course of any judicial or administrative proceedings in response to an order of the court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement – We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Medical Examiners and Funeral Directors – We may disclose protected health information to a coroner or medical examiner for identification purposes, determining causes of death for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to funeral directors, as authorized by law, in order to permit the funeral director to carry out their duties.

For Organ, Eye or Tissue Donation – We may use or disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

To Avert a Serious Threat to Health or Safety – We may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public. We may also disclose protected health information if it is necessary for the law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security – When the appropriate conditions apply, we may use or disclose protected health information of individuals who are armed forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the department of veterans affairs of your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military service. We may also release protected health information about you to authorized federal officials for intelligence, counterintelligence, to provide protection to the President, other authorized persons or foreign heads of state, to conduct special investigations and for other national security activities.

For Worker's Compensation – We may disclose your protected health information as authorized to comply with worker's compensation laws and other similarly legally established programs.

When an Inmate – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

For Research – Under certain circumstances, we may use and disclose protected health information about you for research purposes. All research projects, however, are subject to a special approval process. With your consent, we may disclose protected health information about you under certain conditions to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the protected health information they review does not leave our facility.

Business Associates – We contract with individuals and entities, referred to as Business Associates, to perform various functions on our behalf or to provide types of services described in this notice. In order for Business Associates to perform their functions or services, we may disclose protected health information to them, but only after they have agreed in writing to safeguard the information. Examples of Business Associates may include our billing company.



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____ (please print) have been offered a copy of **Definition Dental Studio's Notice of Privacy Practices**. I consent to Definition Dental Studio using and disclosing my protected health information for purposes of treatment, payment and health care operations and other purposes listed under the "How We May Use or Disclose Protected Health Information" section of the Notice of Privacy Practices, consistent with requirements of applicable law. A copy of Definition Dental Studio's Notice of Privacy Practices is available both in our office, as well as online at DefinitionDentalStudio.com.

Signature of Patient, Parent or Guardian

Date

OFFICE USE ONLY BELOW THIS LINE

We attempted to obtain written acknowledgment of Receipt of our Notice of Privacy Policies, but the Acknowledgment could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining the acknowledgment
- Other (Please specify)



TREATMENT AGREEMENT

Patient Name _____ Date _____

Treatment _____

Patient Portion for Treatment \$ _____

INSURANCE CLAIMS

We are happy to assist you in submitting your insurance claims. The estimate provided by this office is considered a guideline until the final insurance payment is received, and the patient's account has been reconciled. We will send you a final statement, if a remaining balance is due after insurance pays their portion.

***If for any reason the estimated amount is not paid by your insurance company the remaining portion is your obligation.**

Our goal is to provide you with optimal care based on your individual needs. Dental treatment is an excellent investment to maintain your overall health, and well-being. To assist you in receiving treatment, we offer several payment options. You may choose to pay cash or any major credit card. Additional options are interest free payment plans.

_____ **Adjustment**

For uninsured patients who pay cash in full prior to treatment.

_____ **Payment at time of treatment**

Payment in full is required on date of service. For your convenience, we accept cash, Visa, MasterCard, Discover, and American Express.

_____ **CareCredit**

No interest options for 6 or 12 month terms

Signature of Patient, Parent or Guardian

Date