Whitaker
FAMILY & COSMETIC DENTISTRY

Today's Date ____/____/_____

**Patient's information**:

Name: _____
Prefered Name _____ M F
Date of Birth: _____
Social Security _____
Driver's License _____
Home Address _____
_____
City State Zip
_____
Home Phone Cell Phone

Do you accept text? Yes No

Place of Employment_____
Work phone # _____

Who referred you to our office? _____
_____

If the patient is a child, who is accompanying the child
Today _____
Mother's Name: _____
_____
Home Address (if not the same as child)
_____
Mother's Social Security DOB Driver's License

Place of Employment:
_____
Phone #

Father's Name _____
_____
Home address (if not the same as child)
_____
Father's Social Security DOB Driver's License

Place of Employment:
_____
Phone #

**Primary Insurnace**
Please circle: Patient Parent/ Guardian Spouse
Employer's phone # _____
Policy Holder Name: _____
Insurance Company: _____
Contract Number: _____
Group Number: _____ DOB: _____

**Secondary Insurance**
Please circle: Patient Parent / Guardian Spouse
Employer _____
Policy Holder Name: _____
Insurance Company: _____
Contract Number: _____
Group Number: _____ DOB: _____

**Contact information**

Spouse's Home Phone: _____

Spouse's Cell Phone: _____

Spouse's Work Phone: _____

Does your Spouse accept text: Yes No

Email Address: _____

# Whitaker Family and Cosmetic Dentistry

Patient Name: _____ Medical Doctor:_____

Allergic to: PreMed required Yes No

Latex Yes No Reason: _____

Medications: _____ Type: _____ Dosage: _____

Other: _____ **CURRENT**

**MEDICATIONS** (Prescription, over the counter and Herbal

| Medication | Dosage | Frequency | Medication | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PAST AND CURRENT MEDICAL CONDITION (**Mark all that apply)

| | **YES** | | **YES** |
|---|---|---|---|
| Under physician's care?<br>Details: | | Women: Pregnant? Nursing? Oral Contraceptives? | |
| Hospitalization/operation(s) last 5 years.<br>Details: | | Kidney Disease ?<br>Dialysis? | |
| Head/neck/mouth injuries? | | Oral Cancer? Year Diagnosed: | |
| Lung disease/Emphysema? | | Family history of head and neck Cancer? | |
| Glaucoma? | | Radiation Treatment to Head/Neck? | |
| Rheumatic fever? | | Chemotherapy? | |
| Past use of Fenphen? | | Eating Disorder? | |
| Heart murmur? | | Stomach: reflux? Ulcer? | |
| Mitral valve prolapse? | | Thyroid disease? | |
| Heart surgery? | | Sjogrens Disease? | |
| Artificial heart valves? | | Fibromylagia? | |
| Pacemaker? | | Autoimmune disease (Lupus/pemphig) | |
| Indwelling defibrillator? | | Arthritis or other joint disorders? | |
| Artificial joints? | | Diabetes? Type: Controlled? Y N | |
| History of Organ Transplant? | | Headaches? | |
| High blood pressure | | Depression: Diagnosed? | |
| Stroke? | | Other Psychiatric Disorders? | |
| Bleeding problem? | | Neurologic Disease? | |
| hemophilia? | | Convulsions? | |
| Anemia? | | Epilepsy/seizures? | |
| Leukemia? | | Cerebral Palsy? | |
| Shortness of breath | | Fainting Dizziness? | |
| Asthma? | | Sexually transmitted diease (STD) | |
| Sleep Apnea? | | History of Human Papilloma Virus 16/18 | |
| Tuberculosis? | | AIDS/HIV positive | |
| Sinus trouble? | | Hepatitis | |
| Cancer? Year Diagnosed: | | Alcohol or chemical dependecy | |

| | YES |
|---|---|
| **ALCOHOL USE?** | |
| Amount per week: How Long: | |
| **FORMER TOBACCO USER?** | |
| Type:<br>Year quit: Quit<br>for how long: | |
| **TOBACCO USER?** | |
| Type:<br>Amount: | |
| How soon after wake up do you use tobacco? Within 5 | |
| Previous attempts to quit: | |
| Are you interested in quiting tobacco now? | |
| | |
| | |
| **DENTAL INFORMATION:** | |
| Previous Dentist: | |
| Last dental visit: | |
| Last dental cleaning: | |
| Frequency of dental exam: | |
| What made you decide to make this dental appointment? | |
| Frequency of brushing: | |
| Frequency of flossing: | |
| What are some typical foods you eat between meals? | |
| What types of beverages do you typically drink between meals? | |
| How often do you chew or suck on hard candy, cough drops or mints? | |
| Do you use fluoridated toothpaste? | |
| Primary source of drinking water? (circle) City water filtered City water unfiltered Bottled water Well water | |
| | |

| **PAST DENTAL TREATMENT** | YES |
|---|---|
| One or more fillings in the last 3 | |
| Family history of decay? | |
| If child, mother history of | |
| Treatment for perio (gum) | |
| Family history of perio disease | |
| Have you had | |
| Have you had oral surgery | |
| Have you had any dental | |
| Treatment for TMJ disorder ? | |
| Do you wear dentures/partials? | |
| | |
| | |
| | |
| | |
| | |
| **DO YOU HAVE CONSISTENT PROBLEMS WITH:** | |
| Dry mouth/excessive thirst? | |
| Sensitive Teeth? Hot Cold Pressure Sweets? | |
| Mouth odor/bad taste? | |
| Cold sores/blisters/oral lesions? | |
| Are you aware of any swelling or lumps? | |
| Sore bleeding gums? | |
| Loose teeth? | |
| Difficulty chewing? | |
| Food packing between teeth? | |
| Do you hear popping, clicking or snapping in jaw area? | |
| Teeth/filling break frequently? | |
| Clinching/grinding habits? | |
| Do you have jaw pain? | |
| Are you nervous about dental work? | |
| | |

# WHITAKER FAMILY AND COSMETIC DENTISTRY

## PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (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 and indirect treatment by other healthcare providers involved in my treatment):**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day to day healthcare operation 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 healthcare 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.

ADA Guide for Compliance with "The New Red Flags Rule for Protection of Identify Theft and Detection Response Program" are in place.

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 in not affected.

Print Patient Name _____

Signature: _____

Please list the Name and Relationship of person(s) with permission other than parent/legal guardian to accompany patient to appointments. The person(s) listed can make decisions about treatment administered at this visit or any future visits, can also make changes to appointments and will be responsible for any co-payment due at the time of the appointment.

Name/Relationship _____ Date _____

Office Personnel _____ Date _____

# WHITAKER FAMILY AND COSMETIC DENTISTRY

## Our office Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of Our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA MASTERCARD, DISCOVER AND

AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS.

WE ALSO OFFER **CARECREDIT** WHICH IS AN EXTENDED

PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

## REGARDING INSURANCE

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time of the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

**Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**Adult Patients**

Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when you arrive for your appointment.

**Minor Patients**

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

**Payment Plans**

Whitaker Family and Cosmetic Dentistry has partnered with Care Credit, a patient financing company. No other payment plans are available

**Missed Appointments**

**Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointment at the rate of a normal office visit ($30).** Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office.

**Billing**

All accounts which have not paid the estimated portion of their bill at the time of service will incur a $3.00 billing charge each month until the balance is paid. Balances which are 60 days old or older will incur a monthly 1.5% finance charge witch equals an 18% per annum rate. There is also a $30.00 returned check fee.

**Refund**

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

**Collection**

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact you credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere.

I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy. This copy is for your records.

_____ _____

Signature of Patient, Parent, or Guardian Date

# Notice of Privacy Practices

**Your Information. Your Rights. Our Responsibilities.**

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

**Your Rights. You have the right to:**

- Get a copy of your dental record
- Correct your dental record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**Your Choices. You have some choices in the way that we use and share your information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Market our services
- Fundraising efforts

**Our Uses and Disclosures. We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a dental examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

**Your Rights.** When it comes to your health information, you have certain rights. **This section explains your rights and some of our responsibilities to help you.**

**Get a copy of your dental record**

- You can ask to see or get a copy of your dental record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your dental record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone, cell phone call or text) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone dental power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:

- Marketing purposes.
- In the case of fundraising. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures.

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

- **Treat you.** We can use your health information and share it with other professionals who are treating you.
  *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  *Example: We use health information about you to manage your treatment and services.*
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities.
  *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research.** We can use or share your information for health research.

**Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.

**Work with a dental examiner or funeral director.** We can share health information with a coroner, dental examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

**Changes to the Terms of this Notice.** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

| | |
|---|---|
| Effective Date of this Notice: | August 1, 2017 |
| Privacy Official: | Dr. Brett Whitaker |
| Address: | 204 McFarland Circle North, Tuscaloosa, AL 35406 |
| Phone: | 205.462.3745 |

Whitaker Family & Cosmetic Dentistry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

# WHITAKER FAMILY AND COSMETIC DENTISTRY

## GENERAL DENTISTRY INFORMED CONSENT FORM

1. EXAMINATION AND X-RAYS
   I understand that the initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan.
2. DRUGS, MEDICATION AND SEDATION
   I have been informed and understand that antibiotics and other medication can cause allergic reactions causing redness, swelling of tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). I understand that failure to take medications prescribed for me in the manner prescribed may offer risk of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition
3. CHANGES IN TREATMENT PLAN
   I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being additional decay on adjacent teeth. I give my permission to the dentist to make any or all changes and additions as necessary.
4. FILLINGS
   I understand that care must be exercised in chewing on a filling during the first 24 hours to avoid breakage, and tooth sensitivity is a common after-effect of a newly placed filling.
5. REMOVAL OF TEETH (EXTRACTION)
   If there is any alternative to removal it has been explained to me. I authorize the Dentist to remove the teeth outlined on treatment plan and any other necessary for the reasons in Paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time.
6. DENTURES – COMPLETE OR PARTIAL
   I realize that full or partial dentures are artificial, constructed of plastic, metal or porcelain. Some of the problems associated with wearing those appliances include looseness, soreness and possible breakage. I understand that most dentures required relining approximately three to twelve months after initial placement. The cost for this procedure is not in the initial denture fee.
7. PERIODONTAL TREATMENT
   I understand periodontal disease is a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

Consent: I understand that dentistry is not an exact science, therefore a reputable practitioner cannot properly guarantee results. I acknowledge that guarantee or assurance has not been made by anyone regarding the dental treatment which I have authorized. I understand that each Dentist is an individual practitioner and is responsible for the dental care rendered. This consent is valid for one year from date signed.

_____ _____

Signature of Patient, Guardian, HCP or POA Date

_____ _____

Please print name of Patient, Guardian, HCP or POA Relationship to Patient