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 and maintaining your dental health.

Patient Information

Name _____ Soc. Sec # _____
Last First MI

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Work Phone _____ Email: _____

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

Patient Employed by _____ Occupation _____

How did you hear about our office? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Primary Insurance

Insured's Name _____ Relation to patient: _____

Birthdate _____ Soc. Sec # _____

Address (if different than patient) _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Member ID # _____

Additional Insurance

Is patient covered by additional dental insurance? Yes No

Insured's Name _____ Relation to patient _____ Birthdate _____

Address _____ Soc Sec# _____

City _____ State _____ Zip _____ Home Phone _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

The information above is true and correct to the best of my belief. I understand that I am responsible for all of the charges for all services rendered to me or any member of my family. I have requested that the dentist bill my insurance company on my behalf and I understand they have estimated my copay. I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable amount of time. If for any reason, my insurance does not pay any portion of the bill, I further agree to make prompt payment of the bill.

Signature of Patient/Guardian _____ **Date** _____

Please complete both sides

Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your Dental Health. The information is strictly confidential and will not be released to anyone without approval. Thank you for completely filling out this questionnaire.

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

Former Dentist_____City, State _____

Y N If we could offer you a simple, effective way of whitening your teeth, would you be interested?
If you could wave a magic wand and change one thing about your smile, what would it be?

_____

Y N Are you aware of clenching or grinding your teeth?
Y N Do you have frequent headaches, earaches or neck pain?
Y N Do you notice clicking or popping in your jaws?
Y N Do you experience pain in your jaws?
Y N Are your teeth sensitive to hot, cold, sweets or pressure? (circle)
Y N Have you ever had any periodontal (gum) treatments?
Y N Do your gums bleed, feel tender or irritated?
Y N Have you ever had a serious/difficult problem associated with any previous dental work?
Y N Do you have bad breath or has anyone ever told you that you have bad breath?
Y N Do you snore or do you feel tired after a full nights sleep?

Please rank the following in the order in which they would KEEP YOU FROM having dental treatment.

_____Fear of Pain _____ Lack of Concern _____ Cost of Treatment _____ Missing Work Time

Medical History

Y N Do you have any current health problems? Explain _____

Y N Have you had any serious illnesses or operations? Explain _____

Y N Are you under a Physician's care now? Explain _____
Y N Are you pregnant OR trying to get pregnant?
Y N Do you smoke or use tobacco?

Family Physician _____ Phone # _____

List all medications or vitamin supplements you're currently taking, (RX or over the counter)_____

_____

List any allergies: _____
Y N Have you ever been told you need to pre-medicate for your dental visits?
Y N Have you taken the medications Bisphosphonate , Fosamax or Fen-Phen/Redux? (circle)

Please Circle All that Apply:

AIDS/ARC/HIV Positive	Alcoholism	Artificial heart valve	Artificial Joints (hip,knee)
Asthma	Bruise easily	Cancer	Chemotherapy
Cortisone Medicine	Diabetes	Emphysema	Epilepsy or Seizures
Glaucoma	Headaches	Heart Murmur	Heart Problems
Heart Surgery	Hepatitis	High Blood Pressure	Kidney trouble Dialysis
Liver Disease	Psychiatric Treatment	Radiation Treatment	Lung Disease/COPD

Signature of Patient or Parent/Guardian of child: _____ Date _____

Doctor's Signature _____Date _____

PLEASE **INITIAL EACH ITEM** TO THE LEFT NEAR THE BULLET.

- As the patient or responsible party, you are ultimately responsible for the total fees for services, even if a dental benefit company is involved.

- If we are contracted with your dental benefit company, generally only your coinsurance for treatment will be due at the time of service.

- A “pre-estimate” or “pre-determination” for treatment is done in some instances to help you determine your financial responsibilities; this is, however, according to the contract between you and your insurance company. This is not a GUARANTEE of coverage or payment to our office and you are ultimately responsible for the total of the treatment fee.

- If you need to reschedule or cancel a cleaning appointment with our hygienist, a 48 hour notice by speaking to a staff member is required to avoid a $50 failed appointment fee.

- If you need to reschedule or cancel a Periodontal Scaling with Jamie, 1 week notice by speaking to a staff member is required to avoid a $100 failed appointment fee for each two hour appointment block.

- If you need to reschedule or cancel a restorative appointment with Dr. Gilmore, 48 hour notice by speaking to a staff member is required for any to avoid a $50 per hour failed appointment fee.

_____ _____

Patient or Guardian Signature Date

Sunflower Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____,(patient) have been offered a copy of this office's Notice of Privacy Practices.

I authorize _____ (*friend or family member*) to have access to my dental records or knowledge of my dental needs or treatment.

_____

{Please Print Name of *friend or family member*}

_____

{Signature of patient or guardian}

_____

{Date}

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002). **Dlb-old/forms/hippaacknowledment**

Sunflower Family Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 02/01/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.