WELCOME TO OUR DENTAL OFFICE

To more efficiently serve you, we will require all of the following information

PATIENT INFORMATION

LAST NAME:____________________FIRST NAME:___________________MI____________
PREFERRED NAME:____________________BIRTHDATE:___________AGE:___________SEX:_______
MARITAL STATUS (S) (M) (D) (W) Social Security Number:__________________________
ADDRESS:____CITY:__________________________
STATE:____________ZIPCODE:____________EMAIL ADDRESS:______________________________
BILLING ADDRESS IF DIFFERENT:____
PREFERRED PHONE #:_____________________OKAY TO CALL WORK? (YES) (NO)
EMPLOYER:____OCCUPATION:_________________
PHONE NUMBER:__________________________ADDRESS:_______________________________
SPOUSE'S NAME:____________________________SPOUSE'S PHONE NUMBER:_______________

IF CHILD, PLEASE LIST:
FATHER'S FULL NAME:________________________FATHER'S PHONE NUMBER:_______________
MOTHER'S FULL NAME:_______________________MOTHER'S PHONE NJMBER:_______________

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE :____________________	SECONDARY INSURANCE:__________________
SUBSCRIBER:____________________________	SUBSCRIBER:____________________________
SUBSCRIBER DATE OF BIRTH:______________	SUBSCRIBER DATE OF BIRTH:_______________
EMPLOYER:______________________________	EMPLOYER:______________________________
INSURANCE CO PHONE#:__________________	INSURANCE CO #:_________________________
SUBSCRIBER ID:_________________________	SUBSCRIBER ID:__________________________
GROUP #:_______________________________	GROUP #:_______________________________
SUBSCRIBER SSN:________________________	SUBSCRIBER SSN:_________________________
PERSON RESPONSIBLE FOR ACCOUNT (If under 18):______________________________	

PERSON TO CONTACT IN CASE OF EMERGENCY:____
PHONE NUMBER:______________________________RELATIONSHIP:_______________________

For the purpose of diagnosing and treating dental/medical conditions, intraoral photos and/or x-rays may be taken. By signing below, you are consenting to take photos and/or x-rays that may be shared with other dental/medical professionals who may assist us in treating or diagnosing your dental/medical condition.

PATIENT/GUARDIAN SIGNATURE:__________________________________DATE:______________

WHOM MAY WE THANK FOR REFERRING YOU:____

MEDICAL HISTORY

PATIENT NAME:______________________________DATE OF BIRTH:____

NAME AND ADDRESS OF PHYSICIAN:____

DATE OF MOST RECENT PHYSICAL EXAM:____

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?: (Y) (N) Pharmacy you use:__________________________________

IF YES, FOR WHAT REASON?:____

HAVE YOU EVER BEEN HOSPITALIZED FOR A SERIOUS ILLNESS OR INJURY?:______________________________________

PLEASE LIST ALL SURGERIES YOU HAVE HAD:____

WOMEN ONLY: ARE YOU PREGNANT OR DO YOU SUSPECT THAT YOU ARE PREGNANT? (Y) (N)

IF SO, HOW FAR?___________________________ARE YOU CURRENTLY BREASTFEEDING? (Y) (N)

ARE YOU ALLERGIC TO: □ PENICILLIN □ SULFA DRUGS □ METALS □ CODEINE

□ LOCAL ANESTHETIC □ LATEX □ OTHER_______________________________

Have you been told to premedicate with an antibiotic for dental treatment **Yes/No** If so, why?________________________________

DO YOU HAVE OR HAVE YOU EVER HAD (Circle One):

HEART MURMUR	(Y) (N)	DIABETES	(Y) (N)
CARDIAC STENT	(Y) (N)	THYROID PROBLEMS	(Y) (N)
INFECTIVE ENDOCARDITIS	(Y) (N)	OSTEOPOROSIS/OSTEOPENIA	(Y) (N)
ARTIFICIAL HEART VALVE	(Y) (N)	TAKEN A BISPHOSPHONATE	(Y) (N)
PACEMAKER	(Y) (N)	ARTHRITIS	(Y) (N)
ORTHOPEDIC IMPLANT (JOINT REPLACEMENT)	(Y) (N)	AUTOIMMUNE DISEASE	(Y) (N)
STROKE	(Y) (N)	EPILEPSY	(Y) (N)
ANEMIA OR OTHER BLOOD DISORDER	(Y) (N)	HIV/AIDS/STD	(Y) (N)
PROLONGED BLEEDING	(Y) (N)	HERPES SIMPLEX ONE	(Y) (N)
KIDNEY/RENAL DISEASE	(Y) (N)	TUMOR, ABNORMAL GROWTH	(Y) (N)
LIVER DISEASE(HEPATITIS/JAUNDICE/CIRRHOSIS	(Y) (N)	RADIATION THERAPY	(Y) (N)
TUBERCULOSIS	(Y) (N)	CHEMOTHERAPY	(Y) (N)
EMPHYSEMA, SHORTNESS OF BREATH	(Y) (N)	RHEUMATIC FEVER	(Y) (N)
BREATHING OR SLEEPING		NEUROLOGIC DISORDERS	(Y) (N)
PROBLEMS(SLEEP APNEA,SNORING)	(Y) (N)	GLAUCOMA	(Y) (N)
ASTHMA	(Y) (N)	PSYCHIATRIC TREATMENT	(Y) (N)
DIGESTIVE DISORDER	(Y) (N)	FREQUENT HEADACHES	(Y) (N)
HIGH BLOOD PRESSURE	(Y) (N)	TOBACCO USE	(Y) (N)
LOW BLOOD PRESSURE	(Y) (N)	ALCOHOL ABUSE/CHEMICAL DEPENDENCY	(Y) (N)

LIST ALL MEDICATIONS, SUPPLEMENTS, AND/OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS:

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PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY NEW MEDICATIONS YOU MAY BE TAKING. I UNDERSTAND THAT THE ADMINSTRATION OF LOCAL ANESTHETIC MAY CAUSE A REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY PERMANENT NUMBNESS, OR MUSCLE SORENES. I UNDERSTAND THAT THE OCCASIONAL NEEDLES BREAK AND MAY REQUIRE SURGICAL RETRIEVAL. I HEREBY AUTHORIZE THE ADMINSTRATION OF SUCH MEDICATIONS AND PERFORMANCE OF SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. OCCASIONALLY, TEETH DON'T RESPOND TO TREATMENT. IF A TOOTH BECOMES SYMPTOMATIC AFTER TREATMENT, IT MAY REQUIRE FURTHER THERAPY. I ACKNOWLEDGE THAT THE HUMAN TOOTH IS A LIVING ORGAN. WHEN TREATED, UNPREDICTED SYMPTOMS SUCH AS HOT/COLD SENSITIVITY, PAIN, AND INFECTION CAN OCCUR WHICH MAY CHANGE THE TREATMENT PLAN AND REQUIRE ADDITIONAL TREATMENT.

PATIENT SIGNATURE____**DATE**______________________

Family Dental Center Financial Policy

Cash Accounts

Payment in full is expected at the time of service unless prior arrangements are authorized through the Financial Department.

We accept checks, cash and all major credit cards.

Insurance Accounts

You must provide us with the necessary information to file your insurance claim. A copy of your insurance card with an address and phone number to your insurance company is necessary for us to verify insurance coverage.

Deductibles and co-pays are due at the time of service.

It is the responsibility of the insurance holder to know about his/her benefits, deductibles, waiting periods, exclusions and yearly maximums. The Financial Department can only estimate what your insurance company will pay and what your co-pay will be.

We allow your insurance company 45 days to pay or respond to your insurance claim. If your insurance company does not pay the claim after 45 days, you are expected to pay any remaining balance in full within 30 days.

All Accounts

I have read the Family Dental Center Financial Policy and understand the payment terms.

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Patient Signature (Parent of Guardian if minor)

FAMILY DENTAL CENTER
Drs Tinnin, Harris, Johnson, Silvestri PLLC
2386 North Green Acres Road
Fayetteville, Arkansas 72703
479-442-8500

Patient Name: ______________________________ Date: _____________

- I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Family Dental Center.
- I may refuse to sign.
- Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.

- I understand that I may request a copy of the privacy policies at any time.
- I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: ___________________ Relationship: _________ Phone: ____________

Name: ___________________ Relationship: _________ Phone: ____________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION AND INFORMATION ABOUT MY DENTAL HEALTH** VIA:

- ☐ Message on: ☐ Home Phone ☐ Cell Phone ☐ Work Phone
- ☐ Text
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ Any of the above

________________________________ ________________________________

Please ***print*** your name Please ***sign*** your name

☐ Patient ☐ Parent ☐ Guardian ☐ Other ________________________

FAMILY DENTAL CENTER
Drs Tinnin, Harris, Johnson, Silvestri PLLC
2386 North Green Acres Road
Fayetteville, Arkansas 72703
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NOTICE OF PRIVACY PRACTICES

This notice is to inform you that your personal health information will only be used for purposes of treatment in our facility and will not be misused or disclosed by / to anyone outside of our practice. You may gain access to this information if you desire.

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 on April 14, 2003 and will remain in effect.

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 or 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 who is currently providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you (i.e. insurance companies).

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

You may give us written authorization to use your health information or to disclose it to anyone for any purpose (e.g. a family member picking up records, referral to dental specialist, etc.) If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give 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 (included 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 or your health information, we will provide you with an opportunity to object to such uses of 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 that 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-Relation Services: Our dental office does not use patient information for any marketing purposes. 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 it is required by law to do so (i.e. missing person, etc.)

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 lawfully authorize federal official's health information required by lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

- Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. You may request access by sending us a letter to the address at the end of this notice. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for any purpose, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or locations and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing. It must explain why the information should be amended. We may deny your request under certain circumstances.

- Questions and Complaints:

If you desire further information about our privacy practices or if you have questions, please contact us. If you are concerned that 1) we may have violated your privacy right, 2) you disagree with a decision we made about access to your health information, 3) in response to a request you made to amend or restrict the use or disclosure of your health information or 4) to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Tinnin, Dr Harris, Dr. Johnson, Dr Silvestri, Privacy Officer, Owner

Telephone: 479-442-8500
Address: 2386 North Green Acres Road, Fayetteville, Arkansas 72703