SCHMIDLE FAMILY DENTISTRY

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 _____

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 _____

SCHMIDLE FAMILY DENTISTRY

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 prescription or over-the-counter medications? ☐ 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

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Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other _____

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ No Known Allergies

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

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

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

SCHMIDLE FAMILY DENTISTRY

Dental Health History

GENERAL ORAL HEALTH HISTORY

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Do you have bad breath?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you have frequent or regular headaches?	☐	☐
Do you have clicking, popping, or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you snore?	☐	☐
Have you ever had serious injury to your head or mouth?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐
Do you vape?	☐	☐

WHAT WOULD YOU LIKE TO CHANGE ABOUT YOUR TEETH?

- ☐ Repair chipped teeth
- ☐ Be able to chew better
- ☐ Close spaces
- ☐ Replace silver filings with white
- ☐ Replace missing teeth
- ☐ Straighten smile
- ☐ replace old crowns or caps that don't match
- ☐ Have less gum showing
- ☐ Whiter

Date of your last dental exam _____ Date of last dental X-rays _____

What is the primary reason for your visit today? _____

_____

How do you feel about your smile? _____

SCHMIDLE FAMILY DENTISTRY

Financial Policy

It is our policy that all fees including co-pays; deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. **If we do not have the correct Insurance information on the date of service and your claim is denied you are responsible for payment.** It is your responsibility to verify if our office is in network with your plan.

Accounts which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subjected to interest charges or placement with collection agencies following due notice.

I understand the above statements, and I agree to the terms set forth:

1. I understand my co-pay, deductible or non-covered service fee is due and payable at time of service.
2. I understand that I am financially responsible for all charges, even if they are not covered by my insurance.
3. If my insurance does not pay, I understand that I am responsible for those charges.
4. In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, Iagree to pay all cost of collection including attorney fees.
5. If my account is sent to collection, I understand I will be dismissed from this practice.
6. **I understand if I fall to give 24-hour advanced notice of cancellation or fall to show up for a scheduled appointment, I may receive a charge of $25. Repeated offenses will be grounds for dismissal from the practice.**

I, the patient or guardian hereby authorize the release of all applicable dental information including, without limitation, copies of all records and X-rays, to referral and/or follow-up dentists other healthcare practitioners or organizations which will be providing subsequent monitoring, care, or treatment in connection with care provided by Schmidle Family Dentistry. I accept responsibility for the dental charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize the dentists and/or clinic to render dental treatment and to release information to process insurance claims and to determine benefits. I also authorize my insurance claim or other benefits to be paid directly to Schmidle Family Dentistry. I further agree that a photocopy of this document Isto be considered as valid as an original.

Signature of Patient, Parent or Guardian _____ Date _____

Printed Name _____ Relationship to patient _____

SCHMIDLE FAMILY DENTISTRY

Consent to Disclose Healthcare Information

It is important for you to know your rights concerning your records and how your Personal Health Information (PHI) is used in our office. Before we begin any health care operations, we must require you to read and sign this consent form stating you understand and agree with how your records will be used.

1. I understand and agree to allow Schmidle Family Dentistry to use my Patient Health Information for the purpose of treatment, payment, health care operations, and coordination of care.
2. Schmidle Family Dentistry has a document called the Notice of Privacy Practices that contains more information about policies and practices used to protect our patients' privacy. I understand that I have the right to read the Notice of Privacy Practices before signing this agreement. The notice is posted in our office, and a written copy will be provided upon request. Schmidle Family Dentistry may update the Notice of Privacy Practices at any time.
3. Under the terms of this consent, I can ask Schmidle Family Dentistry to restrict how my personal health information Is used or disclosed to carry out treatment, payment, or health care operations.
4. I understand that Schmidle Family Dentistry does not have to agree to my request. If Schmidle Family Dentistry does agree to my request, I understand that agreed limits will be followed.
5. I understand that I have the right to cancel this consent in writing to Schmidle Family Dentistry. If I do cancel this consent, I understand that Schmidle Family Dentistry may have used or disclosed information about me and canceling this consent would not apply to the information already used or disclosed.
6. I understand that if I cancel this consent, Schmidle Family Dentistry does not have to provide any further healthcare services to me.
7. I grant Schmidle Family Dentistry permission to view my prescription history from external sources.

I understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

I have been given to opportunity to review a current copy of ***Schmidle Family Dentistry's Privacy Policy***.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Printed Name Relationship to patient

SCHMIDLE FAMILY DENTISTRY

Appointment Reminder Permission

I grant my permission to Schmidle Family Dentistry to remind me of upcoming scheduled appointments in the following ways: *(Please check all that apply.)*

- ☐ Email _____
- ☐ Text Message (please include area code) _____
- ☐ Voice Message (please include area code) _____

In addition, I grant my permission to Schmidle Family Dentistry to periodically notify me of office announcements or when I am due for a hygiene appointment.

I understand that standard text message rates may apply, and that **I may opt out of this service by replying "STOP" to any message received.** I may also ask to be removed from this service at any time.

_____ _____

Signature of Patient, Parent or Guardian | Date

_____ _____

Printed Name | Relationship to patient

SCHMIDLE FAMILY DENTISTRY

Notice of Privacy Practices

Effective date: March 1, 2020

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 **Schmidle Family Dentistry**. 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.

Schmidle Family Dentistry 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 615-859-1910. 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 as 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.

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 615-859-1910. 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.

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.