Patient Information

Date:___________________________

Patient Name: ____ Preferred Name:_________________

Last First MI

Birth Date: _______________________________ Female Male

Social Security Number: ____________________________________ Married Single Child Other______________

Phone: Home_________________________ Work _________________________ Cell_______________________________

Email:____

Address:____ Apt #____________________

City: ____ State:_____________ Zip: ____________________

Emergency Contact: __________________________ Phone: ____________________ Relationship: _____________________

Preferred method of contact: (circle) cell work home email text

Referral Information

Whom may we thank for referring you to our practice? ____

Spouse or Responsible Party Information

The following information is for: ____ the patient's spouse ____the person responsible for payment ______ self

Name: ____

Social Security Number: ____ Birth Date: _____________________________

Phone: Home_________________________ Work _________________________ Cell_________________________________

Address: ____ Apt #_____________________

City: ____ State: _______________ Zip: _______________________

Insurance Information

Primary

Name of Insured: __________________________________SSN#_______________________ Date of Birth__________________

Policy #____ Group #__________________________________

Insured's Address: ____

Street City State Zip

Insured Employer Name: ____

Employer's Address: ____

Street City State Zip

Patient's Relationship to Insured: ___Self ___Spouse ___Child ___Other_______________________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: __________________________________SSN#_______________________ Date of Birth__________________

Policy #____ Group #__________________________________

Insured's Address: ____

Street City State Zip

Insured Employer Name: ____

Employer's Address: ____

Street City State Zip

Patient's Relationship to Insured: ___Self ___Spouse ___Child ___Other_______________________

Insurance Plan Name and Address: ____

Patient____ Date ________________________

Please Rate Your Smile: 1 2 3 4 5 6 7 8 9 10

Would you like to change how your teeth look? If so, how? ____

____

Do you feel rested in the morning? _________________ Had a sleep study? (if yes, date) ________________________________

Diagnosed with a sleep breathing disorder? __________ If so, what was diagnosis _____________________________________

Are you Allergic to any of the following? Circle all that apply.

Penicillin
Latex
Aspirin
Codeine
Local anesthetic/Novocaine
Nitrous Oxide
Metals
Nuts
Vicodin/Norco
Percodan
Food
Other __________________

Have you ever had or been diagnosed with any of the following? Circle all that apply.

AIDS
Allergies (Pollen Dust)
Alzheimer's Disease
Anemia
Arthritis/Gout
Artificial Joints
Asthma
Blood Disease
Cancer/Chemotherapy
Cold Sores
Congenital Heart Disorder
Cholesterol – High
Diabetes I II
Drug/Alcohol Addiction
Dry Mouth
Emphysema/Lung Disease
Epilepsy/Seizures
Glaucoma/Eye Disease
Heart Attack/Failure
Heart Murmur/Irregularity
Hepatitis A/B/C
Herpes
High Blood Pressure
Hypoglycemia
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Migraines
Mitro Valve Prolapse
Orthodontics
Osteoporosis
Periodontal Treatment
Psychiatric Care
Radiation Treatment
Scarlet/Rheumatic Fever
Sickle Cell Disease
Skin Disease
Stroke
Stomach Problems/IBS
Thyroid Disease
Transplant
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Nervous Disorder

Taken medication for osteoporosis or bone health? Injection IV Oral

Have you ever been advised to pre-medicate for your dental appointment? Y / N
Are you currently under the care of a physician? Y / N
If yes, please explain: ____
Have you been admitted to a hospital or needed emergency care during the past two years? Y / N
If yes, please explain: ____
Previous Surgeries: ____
Current Medications – Prescribed and Over the Counter: ____

____

Are you or have you ever been a tobacco user? Y / N If yes, date started: ________________ Date quit:________________
Women – Are you pregnant? Y / N If yes, how many weeks?____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Patient or Guardian Signature____ Date___________________

Doctor Signature ____ Date___________________

Patient____________________

Patient Responsibility

Authorization for Treatment

_____ I authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my or my dependent's dental needs.

_____ Upon such diagnosis, I authorize doctor to perform all recommended treatment for me or my dependent which has been mutually agreed upon by me to employ such assistance as required.

_____ I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

Consent for Treatment of a Minor

I ___________________________ declare that I am the parent or guardian of a patient, who is a minor, and am authorized to give the consents for treatment listed above.

Signature____ **Date**_______________________

Notice of Information Practices (You may refuse to initial this acknowledgement.)

_____ I have read and fully understand TimberView Family Dentistry's Notice of Information Practices.

Notice of Dental Warranty

_____ I have been given a copy and understand the minimum 6 month recall required by Limited Dental Warranty.

Missed Appointments

_____ I understand that I must give 48 hours notice for any appointment that I cannot keep. TimberView Family Dentistry does charge patients for missed appointments; they also reserve the right to dismiss patients who fail to give prior notice.

Financial Policy

_____ I understand that ALL responsibility for dental services provided in this office for myself or my dependents is mine. Payment is due and payable at the time services are rendered. If insurance is to be used, copay is due and payable at the time services are rendered.

Insurance

_____ I understand that any dental benefit program that I participate in is a contract between myself, my employer, and the insurance company. TimberView Family Dentistry is not a party to that contract and can only file claims as a courtesy to our patients. I understand that all services and fees may not be fully covered by an insurance carrier and that I am ultimately responsible for the payment of ALL dental services provided in this office for myself or my dependents.

_____ I understand that TimberView Family Dentistry will estimate my insurance coverage but due to the many variables such as deductibles, annual maximums, usual and customary fee schedules, non-covered procedures and other restrictions, this office CANNOT guarantee coverage.

_____ I understand that TimberView Family Dentistry will file the forms necessary to assure I receive the benefit of my dental insurance. They will allow 90 days for the insurance company to pay. Any unpaid insurance balance over 90 days will be transferred to my account and due in 30 days.

_____ I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my name and signature and any other required information on dental claims for services provided to me and my dependents. I authorize payment of claims to this office.

Payment Options

We want our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning treatment.

- Other insurance or illumitrac
- Cash or Check (with no insurance) (5% savings)
- Patient Financing (90 day INTEREST FREE loans and longer interest bearing loans are available)
- Procedure Financing (For the procedures that require multiple appointments, you may make 2 equal payments. The first payment is due on the day the procedure is begun and the second payment is due on the day it's delivered. The negative here is no discount.)

I comprehend the information on this form and understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Printed Patient Name: ____ Date: _____________________

Witness Signature: ____

Parent or Responsible Party Signature: ____

Relationship to patient: ____

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 April 14, 2003, 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 the 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 for services we provide 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 for treatment, payment or 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 in connection with our 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 is 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 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 judgement 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.

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 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.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities.

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 location, 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 and explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information list 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.

Practice Administrator

Telephone Number: 405-737-0404

Address: 1342 S. Douglas Blvd., Suite B

Midwest City, OK 73130

Dental Warranty

We stand behind what we do.

We are proud of our dental services and what they do for our patients. The long-term success of our dental treatment for you is dependent on several things:

How well you care for your teeth.

Eating a sensible diet and adhering to the schedule we set for the frequency of your professional examinations, cleanings, and x-rays.

The products we recommend for you and frequency of professional continuing care visits depends on your individual situation.

If restorations fracture with normal use, we will replace or repair at no additional charge. This does not include accidents that could also break normal, healthy teeth. Breakage or fracture of the natural tooth supporting a restoration is not covered by this warranty. Composite restorations done as a compromised form of treatment (instead of a crown, inlay, or veneer) are not covered under this warranty.

Porcelain Crowns, Bridges, Inlays, Onlays, Porcelain Veneers: 5 years

Gold and Porcelain Fused to Metal Restorations: 5 years

Composite Fillings or Bonding: 2 years

Sealants: 2 years

Dentures and Partials

We will warranty dentures and partials for a period of five years if a tooth or the denture breaks under normal use. Accidents such as dropping your denture are not covered. Due to the nature of dentures, we cannot guarantee your comfort or ability to accommodate these artificial replacements.

Dentures patients are recommended for yearly check-up appointments for prosthesis maintenance, exam, and oral cancer screen.

Conditions

To keep this warranty valid you must:

- Maintain uninterrupted member in our practice
- Keep your prescribing regular continuing care appointments (no less than every 6 months)
- Maintain your account in good standing
- Have all recommended dental treatment(s) performed, including the treatment of jaw-occlusal dysfunction and use of bruxism guards if recommended

This warranty does not include anything not mentioned above, including gum line desensitizing, root canal therapy, night guards, nor does it cover damage to teeth or dental prosthesis caused by accidents, trauma, neglect, or improper use (grinding, clenching, chewing ice, or biting non-food items).

____ ________________________

Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form la used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign this Acknowledgement****

I ____ have received a copy of this office's Notice of Privacy Practices.

Print Name: ____

Sign: ____ Date: _______________________________

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release Information regarding you, covered under the Privacy Act to people other than yourself.

I, ____authorize the following person(s) to have access to Information covered under the Privacy Practices regarding myself.

____
(Please Print Name & Relationship)

____
(Please Print Name & Relationship)

____
(Please Print Name & Relationship)

For Office Use Only

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

_______ Individual refused to sign

_______ Communication barriers prohibited obtaining the acknowledgment

_______ An emergency situation prevented us from obtaining the acknowledgement

_______ Other (please specify) ____