TROY DENTAL STUDIO

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 carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by 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 14th 2003, and will remain in effect until we replace it.

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 our office.

USES AND DISCLOSURES OF INFORMATION

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

Treatment: We may use or disclose your health information to another dentist or health care provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend, or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you have given us permission to do so.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state workers' compensation laws.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

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

TROY DENTAL STUDIO

NEW PATIENT HISTORY AND INFORMATION

CONFIDENTIAL INFORMATION FOR OUR FILES

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

DATE OF BIRTH: _____ **DRIVERS LISENCE NUMBER:** _____

SOCIAL SECURITY NUMBER: _____ **EMAIL ADDRESS:** _____

PHONE NUMBER: HOME: _____ **CELL:** _____ **WORK:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

REFERRED TO TROY DENTAL STUDIO BY: _____

PARENT OR GUARDIANS NAME (IF MINOR): _____

IN CASE OF EMERGENCY, CONTACT: _____ **PHONE:** _____

PREVIOUS DENTIST: _____

PRIMARY DENTAL INS COMPANY: _____

NAME OF SUBSCRIBER: _____ **GROUP NUMBER:** _____

SS/ID NUMBER OF INSURED: _____ **DATE OF BIRTH OF INSURED:** _____

EMPLOYER OF INSURED PERSON: _____

PHYSICIAN: _____ **PHYSICIAN PHONE:** _____

I authorize my insurance benefits to be paid to Troy Dental Studio. I understand I am ultimately financially responsible for all services I receive including co-pays, deductibles, and non-covered services. Payment is expected at time of treatment, unless other arrangements have been made.

SIGNED: _____ **DATE:** _____

TROY DENTAL STUDIO

MEDICAL HISTORY

CONFIDENTIAL INFORMATION FOR OUR FILES

1. Do you have a specific dental problem? ☐ **NO** ☐ **YES**
2. Do you chew on one side of your mouth? ☐ **NO** ☐ **YES**
3. Do you clench or grind your teeth during the day or night? ☐ **NO** ☐ **YES**
4. Any jaw pain or discomfort? ☐ **NO** ☐ **YES**
5. Do you have any unhealed injuries, growths, or inflamed areas in your mouth? ☐ **NO** ☐ **YES**
6. Do your gums bleed when you brush or floss? ☐ **NO** ☐ **YES**
7. Bad breath? ☐ **NO** ☐ **YES**
8. Dry mouth? ☐ **NO** ☐ **YES**
9. Sensitivity to hot, cold, sweets, or biting? ☐ **NO** ☐ **YES**
10. Have you ever had periodontal (gum) disease or surgery? ☐ **NO** ☐ **YES**
11. Any difficult extractions in the past? ☐ **NO** ☐ **YES**
12. Have you ever had prolonged bleeding after a past extraction? ☐ **NO** ☐ **YES**
13. Are you currently taking any prescription or non-prescription drugs or medicine? ☐ **NO** ☐ **YES**
    If yes; please list name, dosage and how often taken: _____
    _____
14. Have you ever taken any medication for Osteoporosis? ☐ **NO** ☐ **YES**
15. Do you take aspirin daily? ☐ **NO** ☐ **YES** Quantity? _____ How Often? _____
16. Do you have any allergic (or adverse) reactions to any medication or substance? ☐ **NO** ☐ **YES**
    If yes, please list here: _____
17. Have you ever had a reaction to epinephrine? ☐ **NO** ☐ **YES**
18. Have you been hospitalized in the last five years? ☐ **NO** ☐ **YES** for: _____
19. Were you born with a heart condition? ☐ **NO** ☐ **YES** Explain: _____
20. Do you have an artificial heart valve? ☐ **NO** ☐ **YES**
21. Do you use tobacco products? ☐ **NO** ☐ **YES** How Often? _____
22. Do you have a prosthesis such as knee or hip replacement? ☐ **NO** ☐ **YES**
    If yes, please specify date/type: _____
23. Do you have a personal history of any of the following? Circle **YES** or **NO**

Heart Surgery or Disease	Y N	Thyroid Trouble	Y N	Sinus Problems	Y N
High Blood Pressure	Y N	Tumors	Y N	Psychiatric Care	Y N
Diabetes	Y N	Cancer	Y N	Fainting Spell	Y N
Rheumatic Fever	Y N	Radiation/Chemotherapy	Y N	Anemia	Y N
Asthma	Y N	Latex Sensitivity	Y N	Hemophilia	Y N
Ulcers/Gastro Problems	Y N	Hepatitis A	Y N	Eye or Ear Problems	Y N
Tuberculosis	Y N	Hepatitis B	Y N	Arthritis	Y N
Kidney or Liver Involvement	Y N	A.I.D.S.	Y N	Epilepsy	Y N
Blood Disease	Y N	H.I.V. Positive	Y N	Special Needs	Y N

24. Are you subject to profuse bleeding? ☐ **NO** ☐ **YES**
25. Woman only: Are you pregnant? ☐ **NO** ☐ **YES** Due Date: _____

SIGNED: _____ **DATE FILLED:** _____
SIGNED: _____ **DATE REVIEWED:** _____
SIGNED: _____ **DATE REVIEWED:** _____
SIGNED: _____ **DATE REVIEWED:** _____

TROY DENTAL STUDIO

Acknowledgement of Receipt of
Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

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

_____
(Please Print Patient Name)

_____
(Signature of Patient, Parent, or Guardian)

_____
(Date)

In addition to the Notice of Privacy Practices, you may also disclose my information to:

Name _____ Phone Number _____

Name _____ Phone Number _____

Name _____ Phone Number _____

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
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)

_____
_____
_____

TROY DENTAL STUDIO

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we will help you reach your maximum allowed benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. Our hope is that any misunderstanding can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor for payment of services. Due to constantly changing insurance contracts, benefits, and deductibles, we are only able to approximate your insurance coverage. As a courtesy to you, we will file your insurance claim at no additional charge. If the insurance company pays less than expected, you will be charged the difference. If we haven't received payment from your insurance carrier after 90 days, we will charge the balance back to you. Final responsibility for payment rests with the person responsible for your account. (Patients who accompany minor children are responsible for the charges incurred.) If you have concerns about the insurance reimbursement, it is your responsibility to contact your insurance carrier to resolve the problem.

Payment for co-payments or other charges are due at the time of service. We accept Visa, MasterCard, and American Express. For your convenience, our office has made arrangements with the dental credit card, Care Credit. We are proud to be able to offer lower monthly payments with an interest free period to our valued patients who qualify for credit. If interested, please ask for details.

If for any reason you request a records or x-ray transfer, an administrative fee will be charged.

If your insurance company does not pay full within 60 days, we may ask you to pay your balance with cash, check, or credit. A fee of $25 will be assessed on returned checks.

If credit is extended for any reason, I authorize your office to obtain my credit report.

I understand that treatment fees quoted are estimated to the best of our ability and are honored up to a three month period and may change after that.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you.

Patient Signature _____ **Date** _____