DR. AMY SMITH DDS LLC

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 10/01/2008, 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

____
Please Print Name

____
Signature

____
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)

____

____

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Elmore Family Dentistry
Dr. Amy Smith

220 Jackson St.
Elmore, Oh 43416
419-862-2232

Our Financial Policy

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum benefits. In order to achieve these goals we need your assistance and understanding of our Financial Policy. For your convenience we offer the following methods of payment.

A. Credit cards we accept are MasterCard, Visa and Discover.

B. For insurance patients, we accept payment directly from the insurance company for the percentage the company will cover. We will gladly accept insurance assignments, but require **that the deductible and non-covered fees be paid at each visit.**

C. Major services: crowns, bridges, implants, root canals, partials, and dentures. Payment of ½ at the initial appointment and the balance upon completion. Should alternate financing become necessary, you will need to make arrangements with our financial coordinator. Unless you speak with us, we will assume that your bill will be paid-in-full at each visit.

Please be aware that in the situations of divorced or separated parents, **the parent bringing a child to our office is responsible for payment on services rendered.** We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We are honored that you have chosen our office for your dental treatment and we appreciate the opportunity to serve you.

_______________________________ Patient or responsible party

_____________ Date

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(800) 243-4675

welcome

PATIENT NUMBER

Age ____________ Date ____________

Patient's Name ______________________ (Last) (First) (Initial) Date of Birth ____________ ❑ Male ❑ Female

If Child: Parent's Name ____________

How do you wish to be addressed ____________

Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street ____________

City ____________ State ____ Zip ____________

Business Address ____________

Telephone: Res. ____________ Bus. ____________

Fax ____________ Cell Phone # ____________

eMail ____________

Patient/Parent Employed By ____________

Present Position ____________

How Long Held ____________

Spouse/Parent Name ____________

Spouse Employed By ____________

Present Position ____________

How Long Held ____________

Who is Responsible for this account ____________

Drivers License No. ____________

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call ____________

Other Family Members in this Practice ____________

____

Whom may we thank for this referral ____________

Patient/parent Social Security No. ____________

Spouse/Parent Social Security No. ____________

Someone to notify in case of emergency not living with you ____________

____

DENTAL INSURANCE 1ST COVERAGE

Employee Name ____________ Date of Birth ____________

Relationship to patient ____________

Employer Name ____________ Yrs. ____________

Name of Insurance Co. ____________

Address ____________

____

Telephone ____________

Program or policy # ____________

Social Security No. ____________

Union Local or Group ____________

DENTAL INSURANCE 2ND COVERAGE

Employee Name ____________ Date of Birth ____________

Relationship to patient ____________

Employer Name ____________ Yrs. ____________

Name of Insurance Co. ____________

Address ____________

____

Telephone ____________

Program or policy # ____________

Social Security No. ____________

Union Local or Group ____________

CONSENT:

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

____

____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

____

DATE ____________

Form No. T110R

REGISTRATION

welcome

PATIENT NUMBER

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Patient's Name ____
Last First Initial Date of Birth

1. Purpose of initial visit ______________________________
2. Are you aware of a problem? ______________________________
3. How long since your last dental visit? ______________________________
4. What was done at that time? ______________________________
5. Previous dentist's name ______________________________
   Address: ______________________ Tel. ______________
6. When was the last time your teeth were cleaned? ______________________________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? .... YES NO
   How often: ______________________________
8. Were dental x-rays taken? .... YES NO
9. Have you lost any teeth or have any teeth been removed? .... YES NO
   Why? ______________________________
10. Have they been replaced? .... YES NO
11. How have they been replaced?
    a. Fixed bridge ______________ Age ______________
    b. Removable bridge ______________ Age ______________
    c. Denture ______________ Age ______________
    d. Implant ______________ Age ______________
12. Are you unhappy with the replacement? .... YES NO
    If yes, explain ______________________________
13. Would you like to know about permanent replacements? .... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: ______________________________
15. Do you clench or grind your teeth? .... YES NO
16. Does your jaw click or pop? .... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? .... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? .... YES NO
19. Does food get caught in your teeth? .... YES NO
20. Are any of your teeth sensitive to: ❒ Hot? ❒ Cold? ❒ Sweets? ❒ Pressure?
21. Do your gums bleed or hurt? .... YES NO
    When? ______________________________
22. How often do you brush your teeth? ______________ When? ______________
23. Do you use dental floss? .... YES NO
    How often? ______________________________
24. Are any of your teeth loose, tipped, shifted or chipped? .... YES NO
25. Are you unhappy with the appearance of your teeth? .... YES NO
26. How do you feel about your teeth in general? ______________________________
27. Do you feel your breath is offensive at times? .... YES NO
28. Have you ever had gum treatment or surgery? .... YES NO
    What? ______________________________
    Where? ______________________________
    When? ______________________________
29. Have you had any orthodontic work? ______________________________
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______________________________
31. Do you have any questions or concerns? .... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______________________________ DATE ______________

DENTIST'S SIGNATURE ______________________________ DATE ______________

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

PATIENT NUMBER

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(800) 243-4675

Patient's Name ______________________________
Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name ______________________________
   Address ______________________________
   Tel: ( )
2. Are you under a physician's care? .... YES NO
   Since when ______________ Why ______________
3. When was your last complete physical exam? ______________
4. Are you taking any medication or substances? .... YES NO
   (If yes, please list medications in comments section or on the back of this form.)
5. Do you routinely take health related substances? (Vitamins, herbal supplements, natural products) . . YES NO
6. Are you allergic to any medications or substances? (please list) .... YES NO
7. Do you have any other allergies or hives? .... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? .... YES NO
9. Are you sensitive to any metals or latex? .... YES NO
10. Are you pregnant or suspect you may be? .... YES NO
11. Do you use any birth control medications? .... YES NO
12. Have you ever been treated for or been told you might have heart disease? .... YES NO
13. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse? .... YES NO
14. Have you ever had rheumatic fever? .... YES NO
15. Are you aware of any heart murmurs? .... YES NO
16. Do you have high or low blood pressure? (please circle) .... YES NO
17. Have you ever had a serious illness or major surgery? .... YES NO
    If so, explain ______________________________
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? .... YES NO
19. Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood, or osteoporosis? .YES NO
20. Do you have inflammatory diseases, such as arthritis or rheumatism? .... YES NO
21. Do you have any artificial joints/prosthesis? .... YES NO
22. Do you have any blood disorders, such as anemia, leukemia, etc? .... YES NO
23. Have you ever bled excessively after being cut or injured? .... YES NO
24. Do you have any stomach problems? .... YES NO
25. Do you have any kidney problems? .... YES NO
26. Do you have any liver problems? .... YES NO
27. Are you diabetic? .... YES NO
28. Do you have fainting or dizzy spells? .... YES NO
29. Do you have asthma? .... YES NO
30. Do you have epilepsy or seizure disorders? .... YES NO
31. Do you or have you had venereal or any sexually transmitted disease? .... YES NO
32. Have you tested HIV positive? .... YES NO
33. Do you have AIDS? .... YES NO
34. Have you had or do you test positive for hepatitis? .... YES NO
35. Do you or have you had T.B.? .... YES NO
36. Do you smoke, chew, use snuff or any other forms of tobacco? .... YES NO
37. Do you regularly consume more than one or two alcoholic beverages a day? .... YES NO
38. Do you habitually use controlled substances? .... YES NO
39. Have you had psychiatric treatment? .... YES NO
40. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ...... YES NO
41. Do you have any disease condition, or problem not listed? If so, explain ______________
42. Is there anything else we should know about your health that we have not covered in this form?
43. Would you like to speak to the Doctor privately about any problem? .... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______________________________ DATE ______________

DENTIST'S SIGNATURE ______________________________ DATE ______________

ANEST.

MED. ALERT

MEDICAL HISTORY

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welcome

PATIENT NUMBER

Patient's Name ______________________________
Last First Initial Nickname Date of Birth

Parent's Guardian's Name ______________________________

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? .... YES NO
2. If not, how long since the last visit to the dentist? ____________
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ... YES NO
4. Does your child eat between meals? .... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? .... YES NO
6. When does your child brush his/her teeth?
   ❒ Upon arising ❒ After eating any food ❒ Right after meals ❒ Before going to bed
7. How does your child receive Fluoride?
   ❒ Community water level ____ ppm ❒ Well water level ____ ppm
   ❒ Fluoride drops or tablets ❒ Fluoride rinse or gel
8. Have any cavities been noted in the past? .... YES NO
9. Does your child suck his/her thumb or fingers? .... YES NO
10. Were any teeth (baby or permanent) removed by extraction? .... YES NO
    Was it suggested that the space be maintained .... YES NO
    Was an appliance placed .... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc? .... YES NO
    If so describe ____________
12. Has your child had any problem with dental treatment in the past? .... YES NO
13. Has anyone in the family, including parents, had orthodontics? .... YES NO
14. Has your child ever received a local anesthetic? .... YES NO
15. Has your child ever had occlusal sealants? .... YES NO
16. Does your child think there is anything wrong with his/her teeth? .... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? .... YES NO
2. Is your child under care of physician? .... YES NO
   If yes, since when and why? ____________
3. Name of physician ____________ Phone ____________
4. Is your child receiving any medication? .... YES NO
   What? ____________
5. Is your child allergic to penicillin, antibiotics or other drugs? .... YES NO
6. Is your child allergic to or sensitive to any metals or latex? .... YES NO
7. Does your child have other allergies? .... YES NO
8. Has your child had any serious illness? .... YES NO
   When ____________ What ____________
9. Has your child ever had surgery? .... YES NO
10. Does your child have a heart murmur? .... YES NO
11. Is surgery contemplated? .... YES NO
12. Does your child experience severe or prolongated bleeding? .... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? .... YES NO
14. Has your child tested positive for hepatitis? .... YES NO
15. Is your child subject to nervous disorders? .... YES NO
    ❒ Fainting? ❒ Seizures? ❒ Dizziness? ❒ Behavioral/Learning problems?
16. Does your child have frequent headaches? .... YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE ______________________________ DATE ____________

DENTIST'S SIGNATURE ______________________________ DATE ____________

ANEST. MED. ALERT

CHILD DENTAL MEDICAL HISTORY

Form No. T131CDM