Nu-Smile Family Dentistry

Date:_____

Name:_____SS#:_____
First Middle Initial Last

Driver's License Number: _____Email:_____

Address:_____City:_____State:_____Zip code:_____

Home Phone:_____ Cell: _____Work:_____

Birthdate:_____ Sex: M F Marital Status: S M D O Occupation:_____

Emergency Contact Name and Number:_____

Referred by: _____ How did you hear about us? _____

DENTAL INSURANCE INFORMATION

Employer of insured: _____ Insured's Social Security Number: _____

Insurance Company: _____ Insured's Date of Birth: _____

Name of Insured:_____ Relationship to patient:_____

MEDICAL HISTORY

Please answer the following questions regarding your health history. The accuracy of your answer is very important to the delivery of safe and appropriate dental care. Thank you.

Are you in good health? Y N

Has there been any change in your general health within the past year? Y N

My last physical examination was _____

Are you under the care of a physician(s)? Y N (If yes, name of physician(s) _____)

Please list ALL medications including the doses that you are taking, including over the counter medications, herbal or holistic remedies, vitamins and minerals.

_____
_____
_____

Circle any of the following that you are currently taking:

Antibiotics	Nitroglycerin	Psychotherapy drugs	Hormone medications
Anticoagulants(blood thinners)	Thyroid Medication	High Blood pressure medications	
Insulin	Cortisone(steroids)	Pain medications	
Aspirin	Birth Control	Cholesterol medications	

Are you allergic to or have any reactions to the following?

Local Anesthetics	Aspirin	Latex	Any metals	Sedatives	Sulfa Drugs
Penicillin	Any antibiotics	Barbiturates	Other (please list)	_____	_____

Please circle any that may apply:

Aids/HIV	Alzheimer Disease	Anemia	Anxiety/Depression	Arthritis
Artificial Joints	Asthma	Autoimmune Disease	Blood Disease	Respiratory Problems
Cancer	COPD	Cortisone Tx	Diabetes	Dizziness
Emphysema	Endocarditis	Epilepsy	Fainting	Glaucoma
Hay Fever	Headaches	Heart Disease	Heart Murmur	Hemophilia
Hepatitis A B C	High Blood Pressure	Jaundice	Kidney Disease	Liver Disease
Meningitis	Mental Disorders	Mouth Ulcers	MVP	Osteoporosis
Pacemaker	Psychiatric Care	Radiation Treatment	Reflux	Rheumatic Fever
Sickle Cell	Sinus Problems	Stomach Problems	Stroke	Thyroid Problems
Tobacco Habit	Tuberculosis	Tumors	Venereal Disease	

Any disease/medical condition not listed: _____

WOMEN ONLY

Are you pregnant? Y N Do you anticipate becoming pregnant? Y N Are you nursing? Y N Are you taking Birth Control? Y N

****WARNING: ANTIBIOTICS MAY ALTER THE EFECTIVENESS OF BIRTH CONTROL. CONSULT YOUR PHYSICIAN FOR ASSISTANCE REGARDING ADDITIONAL METHODS OF BIRTH CONTROL*******

Dental History

Do you have regular (6) month visits to the dentist? Y N Who was the last dentist you saw? _____

When was the last visit to a dentist? _____ Procedure done_____

How often do you brush/floss? _____ Ever had an unusual reaction to dental work? _____

Ever any complications following dental treatment Y N (If yes explain) _____

Ever treated with bisphosphonates such as (Zometa, Aredia, Actonel, Fosamax,Boniva)

Any clicking or popping of the jaw? Y N Do you clinch or grind your teeth? Y N Any of your teeth loose/mobile? Y N

Are you happy with the appearance of your teeth Y N (If no please explain) _____

What is the reason for your visit today? _____

Are there any other concerns your feel the doctor should be aware of? _____

CONSENT FOR TREATMENT AND ACKNOWLEDGMENT OF WAIVER

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the information I have provided is complete and correct. I understand that providing incorrect information can be dangerous to my (or patients) health. I will inform this dental of ANY CHANGES in my medical or dental status at the earliest possible time, and I agree to do so. I give permission to the dentist/staff to obtain from my physician any additional information needed to provide me with the best dental treatment possible. I give consent for me or my child to have dental treatment performed by D. Sherry Colvin and her staff. I understand there are risks involved with the administration of local anesthetics, any errors or omissions that I may have made in completion of this form.

Nu-Smile Family Dentistry Office Policies for the following:

Appointments:

If for any reason I have to change or cancel an appointment, I will give a full (48) hours' notice. Otherwise I fully understand that I will be charged a missed/broken appointment fee. I acknowledge and understand that this will be due and payable prior to being seen at my next visit in the office. I also acknowledge that if I no show for an appointment that I will have to pay for treatment prior to making another appointment.

Multiple Family Appointments:

We try very hard to accommodate our families in the practice. We realize that it is sometimes easier to make more than one family member at the same time or back to back. We will do this, however if there is ever any reason that is does not work out, and we do not have a full (3) day notice, we will not be able to appoint that way again. The next appointments will have to be on separate days. We are sorry for any inconvenience, but when more than one cancels, it is hard to fill at short notice

Non-Confirmed Appointments:

Our office confirms appointments (48) hours in advance. If we have to leave a message, we do ask that we receive a call back with a confirmation. If we do not receive a confirmation from you in 24 hours prior to your appointment; your appointment will be cancelled. So please give us good contact numbers in which to get in touch with you. ** **LESS THAN 48 NOTICE A $50.00 CHARGE WILL BE INCURRED FOR ANY DOCTOR APPOINTMENTS AND A $25.00 CHARGE WILL BE INCURRED FOR ANY HYGIENE APPOINTMENTS****

Insurance:

I certify that I and/or my dependents have insurance coverage with _____ and I assign benefits directly to Dr. Colvin. I also understand that if for some reason benefits are sent to me I am to bring the check along with any necessary papers that may have accompanied the claim to be given any adjustments that I may be entitled. **I understand that I am financially responsible for all charges incurred whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

Financial:

It is the policy of this office to file insurance as a courtesy for our patients. Your insurance is not a guarantee of payment. If for any reason, my insurance does not pay, I acknowledge that I am responsible for following up and communicating with my dental carrier. Statements are mailed monthly for un-paid balances. The patient is ultimately responsible for all charges incurred, regardless of what may be expected from any dental carrier. ****ALL RETURNED CHECKS WILL BE SUBJECT TO AN ADDITIONAL $50 COLLECTION FEE****

****Any Deposits made are non-refundable****

ACKNOWLEDGEMENTS OF THE COMPLETE UNDERSTANDING AND AGREEING TO COMPLY WITH THE OFFICE POLICIES OF NU-SMILE FAMILY DENTISTRY AND DR. SHERRY C. COLVIN

I_____ (patient or guardian) have read and fully understand the policies of this establishment and agree to all of them without question.

_____ _____

Signature of patient or guardian **Date**

Nu-Smile Family Dentistry Notice of Privacy Practices

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.

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Nu-Smile Family Dentistry

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Nu-Smile Family Dentistry's Privacy Official.

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on February 5th, 2018.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is February 5th, 2018

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Photo Release Form

I grant to Nu-Smile Family Dentistry, its representatives and employees the right to take photographs of me. I authorize Nu-Smile Family Dentistry to copyright, use and publish the same in print and/or electronically.

I have read and have understood the following:

Signature: _____ Date: _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164) **

****Authorization****

I authorize Nu-Smile Family Dentistry (healthcare provider) to use and disclose the protected health information described below to _____ (individual you allow seeking the information)..

****Extent of Authorization****

I authorize the release of my complete health/dental record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment,or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient