

ALABAMA DENTAL ASSOCIATES PATIENT INFORMATION

PATIENT

Name _____ Address _____
City _____ State _____ Zip _____
Home Phone: _____ Work Phone _____ Birth Date: _____
Social Security # _____ Sex (M/F) _____ Marital Status _____
Employer _____ Email Address _____

PERSON RESPONSIBLE FOR BILL (IF DIFFERENT THAN PATIENT)

Name _____ Billing Address _____
City _____ State _____ Zip _____
Home Phone: _____ Work Phone _____ Birth Date: _____
Social Security # _____ Sex (M/F) _____ Marital Status _____
Employer _____ Email Address _____

DENTAL INSURANCE COVERAGE (Yes/No) _____

Yes Provide an insurance card to the desk and answer the following questions.

No Skip to "Referred By" below.

PERSON PROVIDING INSURANCE (IF DIFFERENT THAN PATIENT)

Name _____ Employer _____
Birth Date _____ Social Security # _____
Relationship to Patient _____ Work Phone _____

MORE THAN ONE DENTAL INSURANCE COVERAGE (Y/N) _____

If **YES** please explain to desk personnel.

REFERRED BY _____

IN CASE OF EMERGENCY NOTIFY _____ PHONE _____

All accounts are due and payable when services are rendered and shall be delinquent and bear interest at a rate of 1.5% per month thereafter. Should full payment not be made when due the underlined agrees to pay all cost of collection, including a reasonable attorney fee not to exceed 33%. The undersigned further waives as to this debt or any renewal thereof all rights of exemption under the laws of Alabama as to real or personal property. The undersigned gives permission to contact employers as well as make inquiries pertaining to this applicant. Further, the undersigned agrees that time for payment may be extended or other indulgence granted by ALABAMA DENTAL ASSOCIATES but that any such action shall not constitute a waiver of any right by the said ALABAMA DENTAL ASSOCIATES.

Signed (By Responsible Party) _____

Today's Date _____

PATIENT MEDICAL HISTORY

PATIENT NAME _____

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | <input type="checkbox"/> | <input type="checkbox"/> | 7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY. | | |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____ | | | 8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____ | | |
| 4. DO YOU USE TOBACCO? | <input type="checkbox"/> | <input type="checkbox"/> | 9. WOMEN ONLY: | | |
| 5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS? | <input type="checkbox"/> | <input type="checkbox"/> | A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. ARE YOU WEARING CONTACT LENSES? | <input type="checkbox"/> | <input type="checkbox"/> | B) ARE YOU NURSING? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | C) ARE YOU TAKING BIRTH CONTROL PILLS? | <input type="checkbox"/> | <input type="checkbox"/> |

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CHEST PAINS | <input type="checkbox"/> KIDNEY DISEASES |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> CARDIAC PACEMAKER | <input type="checkbox"/> EASILY WINDED | <input type="checkbox"/> AIDS OR HIV INFECTION |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> STROKE | <input type="checkbox"/> THYROID PROBLEM |
| <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> ANGINA | <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> HEPATITIS / JAUNDICE |
| <input type="checkbox"/> FAINTING / SEIZURES | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> RADIATION THERAPY | <input type="checkbox"/> STOMACH TROUBLES / ULCERS |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> CANCER | <input type="checkbox"/> RECENT WEIGHT LOSS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> LIVER DISEASE | |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> HEART TROUBLE | |

COMMENTS

PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- | | | | |
|---|--------------------------|---|--------------------------|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? | <input type="checkbox"/> | 8. DO YOU HAVE FREQUENT HEADACHES? | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS? | <input type="checkbox"/> | 9. DO YOU CLENCH OR GRIND YOUR TEETH? | <input type="checkbox"/> |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS? | <input type="checkbox"/> | 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY? | <input type="checkbox"/> |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? | <input type="checkbox"/> | 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST? | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | <input type="checkbox"/> | 12. HAVE YOU HAD ANY ORTHODONTIC WORK? | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES? | <input type="checkbox"/> | 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS? | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? | | 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> |
| A) CLICKING? | <input type="checkbox"/> | 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS? | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)? | <input type="checkbox"/> | | |
| C) DIFFICULTY IN OPENING OR CLOSING? | <input type="checkbox"/> | | |
| D) DIFFICULTY IN CHEWING? | <input type="checkbox"/> | | |

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X

PATIENT, PARENT OR GUARDIAN

DATE

ALABAMA DENTAL ASSOCIATES NOTICE OF PRIVACY PRACTICES

This Notice Describes How Health Information About You May be Used and Disclosed And How You Can Gain 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. This notice takes effect April 14, 2003.

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. Any changes will be made available to you.

You may request a copy of our privacy notice at any time.

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.

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.

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, and other national security activities. We may disclose to correctional institution or law enforcement official 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.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

We support your right to the privacy of your health information. 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, you may complain to us using the contact information listed at the end of this notice.

Contact Officer: Regina Murphy, Office Manager
3920 Grants Mill Road
Birmingham, AL 35210
Phone# 205-956-8977
Fax#205-956-8340

ALABAMA DENTAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's
(Please Print Name)
Notice of Privacy Practices.

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 attained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
