

PATIENT INFORMATION

Emergency Contact Name _____

Today's Date _____

Phone # _____

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____ ☐ Male ☐ Female

Cell Phone _____

Birthdate _____ Age _____ Social Security Number _ _ _ - _ - _ _ _

Employer _____ Driver License #: _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed**RESPONSIBLE PARTY INFORMATION** (if different from above)

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____ Cell Ph. _____

Birthdate _____ Age _____ Social Security Number _ _ _ - _ - _ _ _

Employer _____ Driver License #: _____

Relationship to Patient _____ ☐ Male ☐ Female Are you a patient? ☐ Yes ☐ No**DENTAL INSURANCE INFORMATION****PRIMARY INSURANCE**

Employee First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ St _____ Zip _____

Birthdate _____ Social Security Number _ _ _ - _ - _ _ _

Employer _____ Group ID # _____

Relationship to Patient _____ Are you a patient? ☐ Yes ☐ No**SECONDARY INSURANCE**

Employee First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ St _____ Zip _____

Birthdate _____ Social Security Number _ _ _ - _ - _ _ _

Employer _____ Group ID # _____

Relationship to Patient _____ Are you a patient? ☐ Yes ☐ No

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please list your medical physician's name _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____

Have you every had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please list _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain _____

Have you ever taken Fosamax, Boniva, Actonel or any ☐ Yes ☐ No

other medications containing bisphosphonates? If yes, please explain _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain _____

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substance? ☐ Yes ☐ No

Do you, or have you taken, Viagra? ☐ Yes ☐ No

WOMEN: Are you?

☐ Pregnant/Trying to get pregnant?

☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? _____

☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other If yes, please explain _____

Do you have, or have you had, any of the following? _____

- | | | | | |
|--|---|---|---|--|
| <input type="radio"/> AIDS/HIV Positive | <input type="radio"/> Cold Sores/Fever Blisters | <input type="radio"/> Glaucoma | <input type="radio"/> Kidney Problems | <input type="radio"/> Scarlet Fever |
| <input type="radio"/> Alzheimer's Disease | <input type="radio"/> Congenital Heart Disorder | <input type="radio"/> Hay Fever | <input type="radio"/> Leukemia | <input type="radio"/> Shingles |
| <input type="radio"/> Anaphylaxis | <input type="radio"/> Convulsions | <input type="radio"/> Heart Attack/Failure | <input type="radio"/> Liver Disease | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Anemia | <input type="radio"/> Cortisone Medicine | <input type="radio"/> Heart Murmur | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Sinus Trouble |
| <input type="radio"/> Angina | <input type="radio"/> Diabetes | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Lung Disease | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Arthritis/Gout | <input type="radio"/> Drug Addiction | <input type="radio"/> Heart Trouble/Disease | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Stomach/Intestinal Disease |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Easily Winded | <input type="radio"/> Hemophilia | <input type="radio"/> Osteoporosis | <input type="radio"/> Stroke |
| <input type="radio"/> Artificial Joint | <input type="radio"/> Emphysema | <input type="radio"/> Hepatitis A | <input type="radio"/> Pain In Jaw Joints | <input type="radio"/> Swelling of Limbs |
| <input type="radio"/> Asthma | <input type="radio"/> Epilepsy or Seizures | <input type="radio"/> Hepatitis B or C | <input type="radio"/> Parathyroid Disease | <input type="radio"/> Thyroid Disease |
| <input type="radio"/> Blood Disease | <input type="radio"/> Excessive Bleeding | <input type="radio"/> Herpes | <input type="radio"/> Psychiatric Care | <input type="radio"/> Tonsillitis |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Excessive Thirst | <input type="radio"/> High Blood Pressure | <input type="radio"/> Radiation Treatments | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Breathing Problem | <input type="radio"/> Fainting Spells/Dizziness | <input type="radio"/> High Cholesterol | <input type="radio"/> Recent Weight Loss | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Frequent Cough | <input type="radio"/> Hives or Rash | <input type="radio"/> Renal Dialysis | <input type="radio"/> Ulcers |
| <input type="radio"/> Cancer | <input type="radio"/> Frequent Diarrhea | <input type="radio"/> Hypoglycemia | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Venereal Disease |
| <input type="radio"/> Chemotherapy | <input type="radio"/> Frequent Headaches | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Rheumatism | <input type="radio"/> Yellow Jaundice |
| <input type="radio"/> Chest Pains | <input type="radio"/> Genital Herpes | | | |

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X

Signature of Patient, Parent, or Guardian

Date

HEALTH HISTORY

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically regarding but not limited to scheduling, appointment reminders, account information, and treatment planning.

I am aware that there may be charges through my phones network provider for text communications.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my cell phone number or email address. I can withdraw my consent to electronic communications by calling Twin Lakes Dental.

(731)642-2244 Paris Office or (731)584-2299 Camden office [practice's telephone numbers].

Email Address (PLEASE PRINT CLEARLY):

_____ @ _____

Phone Number for Electronic (texting) Communication: _____

Patient or (Responsible Party) Signature: _____

Date: _____

TWIN LAKES DENTAL ASSOCIATES

PRINT PATIENT NAME _____

CONSENT OF TREATMENT

The undersigned hereby authorizes the doctor and staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis to the patient's dental needs.

I also authorize the doctor and staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I authorize Twin Lakes Dental to file my insurance. I understand that filing insurance is a courtesy and it is my responsibility to know my own benefits. Any service not covered by my plan is my responsibility. I also understand that all responsibility for payment for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event payments are not received within 90 days, I understand that a finance charge of 1 ½ % (18%APR) may be added to my account. If this account should be turned over to a collection agency, I accept full responsibility for collection fees, attorney fees, or other fees necessary to collect this account.

Patient/Responsible Party Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Twin Lakes Dental Associates Notice of Privacy Practices.

Patient/Responsible Party Signature _____ Date _____

RELEASE OF HEALTH INFORMATION

Our office's confidentiality and the Federal Guidelines require the treatment, appointments and/or account information be discussed with the patient only and/or guardian (if under the age of 18). If you desire this information to be given to someone other than patient and/or guardian then your authorization is required. Please fill out consent to release this information.

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

Patient/Responsible Party Signature _____ Date _____

TWIN LAKES DENTAL ASSOCIATES

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 Twin Lakes Dental ("Dental Practice"). "We" and "our" means our Dental Practice. "You" and "your" means our patient.

II. 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.

III. 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.

IV. 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.

V. 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.

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, 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.

VI. 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.

VII. 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 8/17/2015.

VIII. How to Make Privacy Complaints

If you have any questions, would like further information about this Notice, or 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 you can contact TWIN LAKES DENTAL ASSOCIATES'S Privacy Official at:

Misty Thorn
405 Tyson Avenue
Paris, TN 38242
(731) 642-2244
mistyt@twinlakesdental.com

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.