TophamDental
Family Care

Patient Information

First Name	M.I.	Last Name	Title	Sex	Birth Date	Patient SS Number

Address	City	State	Zip Code	Telephone (Home)

Employer	Employer Address	City	State	Telephone (Work)

Email Address	**Telephone (Cell)**

Person Responsible For Account -if other than patient-

First Name	M.I.	Last Name	Title	Sex	Birth Date	SS Number

Address	City	State	Zip Code	Telephone (Home)

Employer	Employer Address	City	State	Telephone (Work)

How did you find us?	I accept responsibility for this account Signature of responsible person, spouse, or other guarantor	Telephone (Cell)

Other family members who are seen in our office (please list name and relationship)

Dental Insurance Information -if no card present-

Primary dental insurance information		**Secondary dental insurance information**	
Carrier (insurance company) name and address		Carrier (insurance company) name and address	
Who is covered? (please circle) Subscriber - Spouse - Dependents	Subscriber's SSN or Insurance ID	Who is covered? (please circle) Subscriber - Spouse - Dependents	Subscriber's SSN or Insurance ID
Subscriber's Birth Date	Insurance Policy Number	Subscriber's Birth Date	Insurance Policy Number
Employee # (If Any) Group Name (If Any) Group # (If Any)		Employee # (If Any) Group Name (If Any) Group # (If Any)	

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, for services rendered or to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Authorized Signature of Covered Person/Employee Date

Authorized Signature of Covered Person/Employee Date

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

Authorized Signature of Covered Person/Employee Date

Authorized Signature of Covered Person/Employee Date

We are happy to submit your insurance forms at no charge. Please be aware that although insurance benefits are assigned to the doctor, responsibility for the account is still between patient and doctor. Predetermination of benefit payable will be done when necessary to prevent misunderstanding between doctor, patient and insurance carrier.

General Health History

Please answer all questions as completely as possible.

Are you under a physician's care now? YES NO Doctor _____ For what condition? _____

Have you ever been advised by a physician to take ANTIBIOTIC PRE-MEDICATION PRIOR TO DENTAL TREATMENT? YES NO

Have you ever been hospitalized or had a major operation? YES NO Please describe _____

Have you ever had a serious injury to your head or neck? YES NO Please describe _____

Are you taking any medications? YES NO Please List _____

Are you ALLERGIC to any medications or substances (eg Latex or Penicillin)? YES NO Please List _____

Women: Please circle any of the following that apply:

pregnant/trying to get pregnant - nursing - taking contraceptives - hormone replacement therapy

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH HISTORY. (A Blank box = no prior history.)

- ☐ Heart Attack
- ☐ Angina/Chest Pain
- ☐ Artificial Heart Valve*
- ☐ Heart Pacemaker
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic/Scarlet Fever
- ☐ Other Heart Trouble/Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Disease
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Excessive Bleeding
- ☐ Hemophilia
- ☐ Recent Blood Transfusion
- ☐ Blood Vessel Surgery
- ☐ Immune System Disorders
- ☐ Arthritis/Rheumatism
- ☐ Gout
- ☐ Cortisone Medication
- ☐ Hay Fever
- ☐ Hives or Rash
- ☐ Cancer
- ☐ Tumors or Growths
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Lung Disease
- ☐ Emphysema
- ☐ Frequent Cough
- ☐ Breathing Problem
- ☐ Asthma
- ☐ Stomach/Intestinal Disease
- ☐ Ulcers
- ☐ Frequent Diarrhea
- ☐ Recent Weight Loss
- ☐ HIV Positive/AIDS
- ☐ Tuberculosis
- ☐ Bloody Sputum
- ☐ Liver Disease
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B or C
- ☐ Jaundice
- ☐ Venereal Disease (STD)
- ☐ Cold Sores/Fever Blister
- ☐ Canker Sores
- ☐ Kidney Problems
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Stroke
- ☐ Epilepsy/other Seizures
- ☐ Glaucoma
- ☐ Osteoporosis
- ☐ Artificial Joint*
- ☐ Alzheimer's Disease
- ☐ Psychiatric Care
- ☐ Drug Addiction/Alcoholism

Use of:

- ☐ Tobacco
- ☐ Recreational Drug Use
- ☐ Blood Thinners (eg Coumadin)
- ☐ Phen-Fen (or similar appetite suppressants)
- ☐ Bisphosphonate medications (eg Fosamax)

antibiotic pre-medication may be required prior to dental treatment

Have you had any other serious illness or surgery not listed above? YES NO

Please Describe _____

I hereby certify that the answers to the foregoing questions are accurate to the best of my ability. Since a change in my medical condition or in medications I take can affect dental treatment, I understand the importance of and agree to take the responsibility to notify the dentist of any changes at any subsequent appointment.

Signature (Parent, legal guardian or authorized agent of patient) _____ Date _____

Medical Updates

I have reviewed my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	Updates	Patient Signature	Reviewed By

General Dental History

Previous Dentist_____ **Period of Treatment**_____ **City/State**_____

Last Dental Visit_____ **Last Full Mouth X-Rays**_____ **Last Complete Dental Exam**_____

What is your immediate dental concern?_____

Is there a reason you are changing dentists? YES NO If yes, please explain _____

Dental Conditions

Please check any of the following that apply:

- ☐ **Bleeding/Sore Gums**
- ☐ **Unpleasant Taste/Bad Breath**
- ☐ **Loose Teeth**
- ☐ **Periodontal (Gum) Treatment**
- ☐ **TMJ Treatment**
- ☐ **Clicking/Popping Jaw**
- ☐ **Clenching/Grinding**
- ☐ **Sensitive Teeth**
- ☐ **Dental Pain**
- ☐ **Orthodontic Treatment (Braces)**
- ☐ **Dentures—full or partial**
- ☐ **Swelling/Tumors**
- ☐ **Implants**
- ☐ **Oral Surgery**

Treatment Authorization & Acknowledgement

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 30 days. In the event of default, I (we) agree to pay 35% finance charge in addition to the indebtedness, together with such collections costs and reasonable attorney fees as may be required to effect collection of this note.

Signature_____ Date_____
Patient, Parent, Guardian or Legally Authorized Agent (must be 18 years or older)

Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices
You may refuse to sign this acknowledgement

I (please print) _____, have received a copy of this office's 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 obtained because:

- -Individual Refused to Sign
- -Communication barriers prohibited obtaining the acknowledgement
- -An Emergency situation prevented us from obtaining the acknowledgement
- -Other (please specify)

TophamDental Family Care

Financial Policy Acknowledgment

The following is to inform you of our office and financial policies. If, at any time, you have questions regarding this policy, please ask any member of our business team.

Payments: We accept cash, check, Visa, MasterCard and Discover. Payments for dental services are due and payable at time of service unless other financial arrangements have been made. We have also partnered with a third-party company to offer flexible deferred interest and extended payment options.

Patients with dental insurance: All services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. As a courtesy to you, we will submit your claims to your insurance plan, along with any pertinent documentation to make the most of the benefits due you. Payment of your estimated portion, such as deductible or co-pay, is due at time of service.

While we do contact your insurance company to obtain information about your plan, it is ultimately YOUR responsibility to know the details of the plan selected by you or your employer. We will provide an ESTIMATE of your recommended treatment, but cannot guarantee payment of insurance benefits. Our estimates cannot be 100% accurate, as many factors are involved in your specific insurance plan's claims process. Details such as whether your specific plan is in or out of network; procedure frequencies and limitations; or percentages of coverage are sometimes not reported accurately to us. If there is still a balance due after the claim is paid, you will be sent a statement. Payment is due by the due date printed on the statement.

At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.

Past Due Accounts: If payment is not received by the due date, your account will be considered past due. A 1.5% monthly finance charge (18% annually) will be added to any balance due over 30 days. Overdue balances unpaid after 90 days will be in default and the following apply: 1) no appointments can be scheduled until the balance is paid in full, 2) the account will be sent to a collection agency or attorney for collection. 3) A finance charge of 35% of the overdue balance will be added to your account, together with such collections costs and reasonable attorney fees as may be required to collect the note. Bounced checks will result in a $35 processing fee.

_____ BY INITIALING, I ACKNOWLEDGE THAT I UNDERSTAND AND ACCEPT THE PAST DUE POLICIES.

Appointment Cancellation Policy: We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved exclusively for you. We require that you give our office 24 hours (business days) notice in the event you need to reschedule your appointment. If you miss your appointment or do not give the required notice, a failed appointment fee of $75.00 will be added to your account. This fee will need to be paid before the appointment can be rescheduled.

_____ BY INITIALING, I ACKNOWLEDGE THAT I UNDERSTAND AND ACCEPT THE CANCELLATION POLICIES.

Patient/Parent/Guardian Signature: _____ **Date:**_____

Print: _____

TophamDental
Family Care

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 June 01, 2019 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.

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Notice of Privacy Practices

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, counterintelligence, 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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice.
If you request copies, we will charge you $0.07 for each page, $25 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
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.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. 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 or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.
We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: D Scott Topham DDS
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