Pell City Dental Center PC

Pell City Dental Center PC
1605 Cogswell Ave
Pell City, Alabama 35125
205-884-2370
www.pellcitydental.com

New Patient Form

Please fill out all the information to the best of your knowledge. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.	Date: / /	Patient #:

Patient Information

Title:	First Name:	Middle Name:	Last Name:	I prefer to be called:

Sex:	Age:	Date of Birth (mm/dd/yyyy): / /	Marital Status:	Social Security #: - -	Driver's Licence State & #:

Home Phone: - -	Work Phone: - -	Cell Phone: - -	E-mail Address:

Home Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone: - -	Occupation:

Employer's Address:	City:	State:	ZIP Code:

Student Status:	School Name (if a full-time student):	Grade:

Best places and times to contact you:	Send appointment reminders via: ❑ Text Message ❑ Email ❑ Mail

Please tell us where you heard about us (check all that apply):

❑ Friend or Relative (name): ❑ Newspaper Ad ❑ Radio Ad ❑ TV Ad
❑ Ad in Mail ❑ Saw our Office ❑ Insurance Company ❑ Our Website
❑ Search Engine (Google, etc.) ❑ Other Website:
❑ Other:

Was our website a factor in your decision to visit our practice? ❍ Yes ❍ No

Name of Spouse (or Parent, if a minor):	Spouse/Parent's Employer:	Spouse/Parent Work Phone: - -	Spouse/Parent Cell Phone: - -

Other family members treated by us:	Additional Comments:

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Emergency Contact

This should be the nearest relative who does not live with the patient.

Title:	First Name:	Last Name:	Relationship to Patient:

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Emergency_Contact Address:	City:	State:	ZIP Code:

Person Responsible for Account

Title:	First Name:	Middle Name:	Last Name:	Relationship to Patient:

Date of Birth (mm/dd/yyyy):	Social Security #:	Driver's Licence State & #:	Holder of Dental Insurance for Patient:
/ /	- -		

Home Phone:	Work Phone:	Cell Phone:	E-mail Address:
- -	- -	- -	

Billing Address:	City:	State:	ZIP Code:

Employment:	Employer's Name:	Employer's Phone:	Occupation:
		- -	

Employer's Address:	City:	State:	ZIP Code:

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Insurance Information

Primary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Secondary Insurance

Insurance Holder's Name:	Date of Birth (mm/dd/yyyy): / /	Relationship to Patient:	Employer:

Member ID:	Group ID:	Insurance Company Name:	Insurance Company Phone: - -

Insured's SSN:	Insurance Company's Address:	City:	State:	ZIP Code:

Authorization

All of the above information is correct to the best of my knowledge. I authorize use of this form on all my insurance submissions and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Pell City Dental Center PC to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Pell City Dental Center PC. I permit a copy of this authorization to be used in place of the original. I give Pell City Dental Center PC, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, insurance, or payment.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

Consent for Treatment

Patient Name:

I hereby authorize the doctor or designated staff to take X-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the above-named patient.

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I have read, understood, and agree to the above treatment policy.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Payment

Does the person responsible for the account already have an account with this office? ❍Yes ❍No

Payment Method

Notice: Payment is due at the time of service unless alternative arrangements have been made in advance. Please choose a method of payment below.

Payment in Full

❍ Cash

❍ Check

❍ Credit Card

Type:	Credit Card Number:	Expiration: / 2016	Card Verification Code: VISA/MC/Discover: 3-digit code printed on back AmEx: 4-digit code printed on front

Your credit card information is kept on file for outstanding account balances.

Payment Plans

Start treatment immediately and pay over time with low monthly payments.

❍ CareCredit

No-Interest Payment Plans

- Pay for treatment over 6 or 12 months with NO interest.
- As long as you pay the low minimum monthly payment each month when due, and the balance in full by the end of the promotional 6- or 12-month term, no interest will be charged on your purchase.

Low-Interest Payment Plans

- Enjoy low monthly payments with the 24, 36, 48, or 60 month extended plans.
- The 14.9% APR is lower than average credit cards and makes convenient, fixed, and low minimum monthly payments possible. This option is available for treatment fees of $1000.00 or more. ($5000.00 or more for the 60 month plan.)

If you choose this option, you can fill out a CareCredit application at our office.

Would you like to discuss our office's financial policy? ❍Yes ❍No

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Payment Policies

Thank you for taking the time to understand our payment policies. For any questions about fees, financial policies, or your responsibilities, please ask one of our office staff for clarification.

For Patients with Dental Insurance

We accept dental insurance assignments, with the understanding that any uninsured portion not covered by your insurance plan is to be paid by you at the time of service. As a courtesy, our office will file all applicable insurance forms. Please note that although we strive to provide accurate information, such information is not a guarantee of payment or eligibility with your insurance company and is only an estimate. Your dental insurance plan is a contract between you, your employer, and the insurance company. Depending on your specific insurance plan, your dental insurance may not fully cover our office dental fees for the services we render. The difference between our office dental fees and your insurance reimbursement is your responsibility.

Returned Checks

Personal checks that are returned due to "insufficient funds" are subject to a $25.00 service fee.

Service Charge

Payment is due at each appointment. I agree to pay any outstanding insurance balance within 60 days. If I do not pay the entire new balance within 60 days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $2.50 for a minimum balance of $25.00) which is an annual percentage rate of 18% applied to the last month's balance. In case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account balance or any future accounts. Please be advised that there is a $50.00 fee charged for missed or broken appointments without 24 hours notice. To avoid this charge, kindly give us a minimum of 24 hours notice for any appointment cancellation. Feel free to contact us at any time with questions you may have.

X-Ray/Records Release

There is a fee of $25.00 for any release of X-rays and/or records.

Minors

Adult patients are responsible for full payment at time of service. The adult accompanying a minor is responsible for payment. This office will not bill a non-custodial parent for services delivered to a minor. For unaccompanied minors, treatment may be denied unless charges have been pre-approved to a credit card or other payment arrangements have been made.

Authorization

Patient Name:

I hereby authorize payment directly to Pell City Dental Center PC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of the above-named patient's dental treatment. The information on the page and the dental/medical histories are correct to the best of my knowledge. I grant the right to Pell City Dental Center PC to release the patient's dental and/or medical histories and other information about the patient's dental treatment to third-party payers and/or other health professionals.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

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Dental History

Previous Dentist

Dentist Name:	Dental Practice Name:	Phone: - -

Address:	City:	State:	ZIP Code:

What did you like about your last dentist?	What caused you to leave your last dentist?

Last Dental Visit

Last Dental Visit (m/y): /	What were you treated for?	Treatment complete? ❍Yes ❍No

What was done at your last dental visit?	Last X-Rays: /	Last Full-Mouth X-Rays: /	Last Cleaning: /

Dental Hygiene

How often do you visit a dentist?	Do you brush your teeth? If yes, how often?	Do you floss? If yes, how often?
Regularly	Yes After every meal	Yes After every meal

Please list other dental hygiene aids (Interplak, toothpicks, etc.) that you use:	Are you interested in regular hygiene cleanings?
	Yes

Today's Visit

Do you have any dental problems, pain, or discomfort at this time? If yes, please describe:
Yes

What is the main reason for your visit today?
❑ Tooth Pain ❑ Check-up ❑ Cleaning ❑ Whitening ❑ Cosmetic Dentistry
❑ Sedation Dentistry ❑ Restorative Dentistry ❑ Other:

What would you like to learn more about?
❑ Whitening ❑ Cosmetic Dentistry ❑ Sedation Dentistry ❑ Implants ❑ Bridges ❑ Veneers
❑ Dentures ❑ Other:

Dental Concerns

Check all that apply.

Teeth

❑ Broken or chipped	❑ Loose/missing filling	❑ Missing teeth	❑ Sensitive to sweets
❑ Crooked	❑ Loose teeth	❑ Mouth sores	❑ Blisters on lips/mouth
❑ Decay	❑ Tooth pain	❑ Sensitive to cold	❑ Orthodontic treatment
❑ Difficulty chewing	❑ Food trap areas	❑ Sensitive to heat	❑ Bad taste in mouth
❑ Discolored	❑ Grinding or clenching	❑ Sensitive when biting	

Gums

❑ Bad breath	❑ Abscessed	❑ Sore	❑ Receding
❑ Red (discolored)	❑ Bleeding	❑ Swollen	❑ Periodontal treatment

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Facial/Jaw Pain

❑ Frequent headaches	❑ Pain in temples	❑ Jaw injury	❑ Pain around ear
❑ Avoid certain foods	❑ Jaw locks open/closed	❑ Head injury	
❑ Popping/clicking	❑ Pain in jaw	❑ Neck injury	

Other Concerns

❑ Smoking/dipping	❑ Orthodontic treatment	❑ Snoring
❑ Biting cheeks or lip	❑ Burning tongue	❑ Teeth straightening
❑ Popping/clicking	❑ Tooth replacement	❑ Retainer
❑ TMJ	❑ Fractured tooth syndrome	❑ Dry mouth
❑ Tooth-colored fillings	❑ CPAP	❑ Wisdom teeth extraction
❑ Wisdom teeth	❑ Implants - Tooth #:	❑ Cosmetics
❑ Nail-biting	❑ Jaw locks open/closed	❑ Smile makeover
❑ Sleep apnea	❑ Stain	❑ Dental phobias
❑ Limited orthodontics	❑ Chew on one side	

Does food tend to get caught between your teeth? If yes, where?

Yes

Do you hold foreign objects (pencils, pipe, pins, nails, fingernails, etc.) with your teeth? If yes, what?

Yes

Have you ever had:

Check all that apply.

❑ Orthodontic treatment	❑ Periodontal treatment	❑ Your bite adjusted
❑ Oral surgery	❑ Your teeth ground	❑ A bite plate or mouth guard

❑ Any canker sores or cold sores on your lips, tongue, gums, or body

❑ A serious injury to the mouth or head? If yes, please describe including cause:

Ratings

1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 bad, 5 good), please rate how you feel your overall dental health is.
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 bad, 5 faithful), over the last ten years, rate how faithfully you have had your teeth cleaned.
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your level of sensitivity to dental procedures?
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 not sensitive, 5 very sensitive), what is your sensitivity to dental cleaning appointments?
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 unhappy, 5 very happy), rate how you feel about the look of your smile.
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 poor, 5 great), how do you rate your quality of sleep?
1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍	On a scale of 1-5 (1 being low, 5 being high), if you snore, how would you rate the severity of your snoring?

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Miscellaneous

Has fear ever been an issue for you in a dental office? ❍Yes ❍No

Has time ever been a factor in getting your dental work done? ❍Yes ❍No

Has the cost of dental treatment been a concern for you? ❍Yes ❍No

If yes, how can we help?

Tell us about your good dental experiences/visits:	Tell us about your bad dental experiences/fears:

What do you like most about your teeth/smile?

Is there anything you don't like about your teeth/smile?

Is there anything you'd like to change about your teeth/smile?

What are your long-term dental goals? How would you like your teeth to feel and look?

What are your short-term dental goals?

Do you have any upcoming event or circumstances (such as weddings, major surgeries, etc.) we should/need to know about? If yes, what and when?

Yes

Is there anything else you feel we should know?

Medical History

How is your general health? ❍Good ❍Fair ❍Poor

Are you currently under medical treatment? If yes, what for?

Yes

Do you require antibiotic pre-medication for your dental work? If yes, what for?

Yes

Physician's Name:	Phone: - -	Last Visit: /

Address:	City:	State:	ZIP Code:

Do we have permission to contact your doctor regarding your care? ❍Yes ❍No

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Have you ever had:

Check all that apply.

- ❑ Abnormal bleeding
- ❑ Allergies
- ❑ Alzheimer's disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Angina
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Artificial bones/joints
- ❑ Artificial hip/joints
- ❑ Artificial valves
- ❑ Asthma
- ❑ Birth defects
- ❑ Blood disease
- ❑ Blood transfusions
- ❑ Bruise easily
- ❑ Cancer
- ❑ Cancer/chemotherapy
- ❑ Chest pain
- ❑ Chronic fatigue syndrome
- ❑ Circulatory problems
- ❑ Cold sores
- ❑ Congenital heart defect
- ❑ Congenital heart lesion
- ❑ Convulsions
- ❑ Cortisone medicine
- ❑ Cough-persistent or bloody
- ❑ Diabetes
- ❑ Difficulty breathing
- ❑ Dizziness
- ❑ Easily winded
- ❑ Emotional problems
- ❑ Emphysema
- ❑ Endocrine problems
- ❑ Epilepsy
- ❑ Excessive thirst
- ❑ Fainting
- ❑ Fever blisters
- ❑ Frequent diarrhea
- ❑ Genital herpes
- ❑ Glaucoma
- ❑ Gout
- ❑ Hay fever
- ❑ Head or face injury
- ❑ Hearing disorders
- ❑ Heart attack/stroke
- ❑ Heart disease
- ❑ Heart murmur/trouble
- ❑ Heart surgery
- ❑ Hemophilia
- ❑ Hepatitis A, B, or C
- ❑ Herpes
- ❑ High or low blood sugar
- ❑ History of substance abuse/drug addiction
- ❑ HIV/AIDS
- ❑ Hives/skin rash
- ❑ Hospitalized for any reason
- ❑ Hypertension (high blood pressure)
- ❑ Hypoglycemia
- ❑ Hypotension (low blood pressure)
- ❑ Intestinal disorders
- ❑ Irregular heartbeat
- ❑ Kidney problems
- ❑ Latex sensitivity
- ❑ Leukemia
- ❑ Liver problems
- ❑ Lung disease
- ❑ Mitral valve prolapse
- ❑ Nervous disorder
- ❑ Numbness of arms or hands
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pain in jaw joints
- ❑ Parathyroid disease
- ❑ Pneumonia
- ❑ Psychiatric problems
- ❑ Radiation treatments
- ❑ Recent weight loss
- ❑ Renal dialysis
- ❑ Rheumatic fever
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Seizures
- ❑ Severe/frequent headaches
- ❑ Sexually transmitted disease
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Sickle cell anemia
- ❑ Sinus problems
- ❑ Sinus trouble
- ❑ Smoker
- ❑ Spina bifida
- ❑ Swelling of feet/ankles
- ❑ Swollen neck glands
- ❑ Swollen, still painful joints
- ❑ Tattoos/body piercing
- ❑ Thyroid disease
- ❑ TMD/TMJ (jaw pain)
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head/neck
- ❑ Ulcers/colitis
- ❑ Venereal disease
- ❑ X-ray or cobalt treatment
- ❑ Yellow jaundice

Have you ever had an adverse reaction or allergies to any medication or substance?

Check all that apply.

- ❑ Acrylic
- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Dental anesthetics
- ❑ Erythromycin
- ❑ Iodine
- ❑ Latex rubber
- ❑ Metals
- ❑ Nitrous oxide
- ❑ Novocaine
- ❑ Penicillin/antibiotics
- ❑ Sedatives
- ❑ Sulfa drugs
- ❑ Tetracycline
- ❑ Valium
- ❑ Xylocaine

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Are you being/have you ever been treated for cancer of any kind? If yes, please explain:
Yes

Are you currently taking or have you ever taken any bisphosphonate drugs? These include: alendronate (Fosamax), clodronate (Ostac, Bonefos), etidronate (Didronel), ibandronate (Boniva), pamidronate (Aredia), risedronate (Actonel), tiludronate (Skelid), zoledronic acid (Zometa). ❍Yes ❍No

Do you take or have you taken Phen-Fen or Redux? ❍Yes ❍No

Do you smoke or chew tobacco? ❍Yes ❍No

Do you use alcohol, cocaine, or other drugs? ❍Yes ❍No

Do you wear contact lenses? ❍Yes ❍No

Are you on a special diet? ❍Yes ❍No

Have you lost or gained more than 10 pounds in the past year? ❍Yes ❍No

Do you use more than two pillows to sleep? ❍Yes ❍No

Have you ever had any excessive bleeding requiring special treatment? ❍Yes ❍No

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? ❍Yes ❍No

Have you been treated in a hospital in the last five years? ❍Yes ❍No

If female, please mark if you are:
❏ Pregnant - If so, please enter your due date or week #:
❏ Trying to get pregnant ❏ Nursing ❏ On birth control

Please list all current prescriptions:

Please list any other serious medical conditions, impending operations, or other medical/dental information that may possibly affect your dental treatment:

Do you wish to talk to the dentist privately about any problems/concerns? ❍Yes ❍No

All of the above information is correct to the best of my knowledge. 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. I understand that the above information is necessary to provide me with dental care in an efficient and safe manner. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /

For office use:
Reviewed by: Title: Date: / /

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Our Office

What do you already know about our office and what are your expectations?

What would it take for you to trust us to be your dentist?

We can look at your mouth from 3 different perspectives. This will help us determine how to best treat you and your specific dental needs. What combination of these would you like us to use for your situation?

❑ As a general dentist ❑ As a cosmetic dentist ❑ As a functional (bite, TMJ) dentist

At what point do you want us to initiate treatment for you?

❍ When something isn't ideal ❍ When something worsens ❍ When my tooth hurts or breaks

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HIPAA 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 the following carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records for several purposes, including treatment, payment, defense of legal matters, to family and friends, and health care operations:

- Treatment includes providing, coordinating, and/or managing health care related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- To Your Family and Friends: 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. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

In some limited situations, the law allows or requires us to use/disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders

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of courts or administrative agencies
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serious threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a "limited data set" for research, public health, or healthcare operations
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures
- Disclosures to "business associations" who perform healthcare operations for our office and who commit to respect the privacy of your health information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish to be omitted from any mailings please provide a written notice. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of December 7, 2016, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

If you think that we have not properly respected the privacy of your health information or that your privacy protections have been violated, you have the right to file a written complaint to us or the U.S.

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Department of Health and Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA and/or to file a complaint, please call or visit or office or contact:

The U.S. Department of Health & Human Services, Office for Civil Rights
200 Independence Avenue, S.W.
Washington D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPAA or The Healthcare Privacy Act). I understand that by signing this consent, I authorize Pell City Dental Center PC to use and/or disclose my protected health information to carry out the following:

- Treatment which includes direct and/or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers, i.e. my dental and/or medical insurance company/companies.
- The day to day healthcare operations of your dental practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected personal health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may request the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to use these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /
If signing on behalf of someone, explain your relationship to the patient:	

For Office Use Only

Patient refused or was unable to sign. Good faith effort was made to obtain acknowledgement of receipt.

The following circumstances prohibited the patient from signing the consent form:			
Describe your good faith effort to obtain the individual's signature on this form:			
Office Personnel Signature:	Office Personnel Name:	Office Personnel Title:	Date: / /

PELL CITY DENTAL CENTER PC

Pell City Dental Center PC
1605 Cogswell Ave
Pell City, Alabama 35125
205-884-2370
www.pellcitydental.com

Oral Cancer Screening Form

Our dental practice continually looks for advances to ensure that we are providing the optimum level of oral healthcare to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause of increasing incidence and mortality rates of oral cancer. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle risk factors. Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases. Oral cancer risk by patient profile is as follows:

- INCREASED RISK: Patients age 18-39, sexually active patients (HPV 16/18)
- HIGH RISK: Patients age 40 and older, tobacco users (ages 18-39, any type within 10 years)
- HIGHEST RISK: Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

Please select one:

❍ YES - I would like to have the oral cancer exam.

❍ NO - I would prefer not to have the oral cancer exam at this time.

Signature (Type your name to sign electronically, or print and sign):	Date (mm/dd/yyyy): / /