PATIENT INFORMATION

(PLEASE PRINT)

NAME_____ DATE_____
Last First MI (Preferred Name)

BIRTHDATE_____ SOCIAL SECURITY #_____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

HOME ADDRESS_____
Street City State Zip Code

PHONE NUMBERS:
Home_____ Work_____ Cell_____ Email_____

PATIENT'S EMPLOYER_____ ADDRESS_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____ PHONE #_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ PHONE #_____

DRIVER LICENSE #_____ BIRTHDATE_____ SOCIAL SECURITY #_____

EMPLOYER_____ WORK PHONE #_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

NAME OF INSURED/EMPLOYEE_____ RELATIONSHIP TO PATIENT_____

BIRTHDATE_____ SOCIAL SECURITY #_____ WORK PHONE #_____

NAME OF EMPLOYER_____ EMPLOYER'S ADDRESS_____

INSURANCE COMPANY_____ GROUP #_____ ID #_____

INSURANCE COMPANY ADDRESS_____ PHONE #_____

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED/EMPLOYEE_____ RELATIONSHIP TO PATIENT_____

BIRTHDATE_____ SOCIAL SECURITY #_____ WORK PHONE #_____

NAME OF EMPLOYER_____ EMPLOYER'S ADDRESS_____

INSURANCE COMPANY_____ GROUP #_____ ID #_____

INSURANCE COMPANY ADDRESS_____ PHONE #_____

PREVENTIVE TREATMENT POLICY

****THE TREATMENT POLICY APPLIES TO ALL PATIENTS EVEN IF YOU DO NOT HAVE INSURANCE.****

As always, we make every effort to maximize the use of your dental insurance benefits on your behalf. Unfortunately, due to changes in the insurance industry over the past few years, insurance companies are reducing your benefits and extending time period limitations for some treatments and preventive procedures. We do our best to follow the guidelines of your insurance company unless it is contrary to what is best for our patients' dental and health well-being. Therefore, we have adopted a preventive policy for our office which will be followed unless YOU let us know BEFOREHAND that you do not wish to have some procedures. Please review your insurance benefits for limitations and coverage.

Our standard procedures are as follows:

For children under 18 years old:
A prophy twice a year
An exam twice a year
Bitewing x-rays twice a year
Fluoride treatment twice a year
A panoramic (full mouth) x-ray every 3 years after age 6

For adults:
A prophy twice a year
An exam twice a year
Bitewing x-rays twice a year
A panoramic (full mouth) x-ray every 3 years

These procedures will be filed on your insurance. YOU will be responsible for any treatment rendered that is not covered by your insurance. PLEASE let us know BEFORE your appointment if you do not desire any procedure. **These standard procedures will be performed unless you tell us otherwise BEFORE your hygienist begins treatment.** If you have any questions, please ask your hygienist. She will be glad to help you. We understand you have a choice in healthcare. **THANK YOU FOR CHOOSING US!**

James T. Gardiner Family Dentistry, P.C. dba Singing River Dentistry
Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, at work or mobile to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date_____ Relationship to patient_____
Signature of patient, parent or guardian

_____ Date_____ Relationship to patient_____
Signature of guarantor of payment/responsible party

James T. Gardiner Family Dentistry, P.C.
dba
Singing River Family Dentistry

Authorization for Disclosure of Health/Dental Information

Patient Name: _____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize **James T. Gardiner Family Dentistry, P.C. dba Singing River Dentistry** to use or disclose the health/dental information of the above named patient as described below.

Individuals (such as family members, friends or caregivers) authorized to receive the information:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

1.) I understand that I have the right to revoke this authorization at any time (except to the extent that action was already taken in reliance on this signed authorization).
2.) I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office of **James T. Gardiner Family Dentistry, P.C. dba Singing River Dentistry.**
3.) I may inspect or copy any information used or disclosed under this agreement.
4.) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.
5.) I understand that if I refuse to sign this authorization, this dental office cannot give out any information to any individuals such as family members, caregivers, or friends.
6.) I understand that any disclosure of information carries with it the potential for any unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
7. If I have questions about disclosure of my information, I can contact Privacy Officer for the office of **James T. Gardiner Family Dentistry, P.C. dba Singing River Dentistry.**

_____ _____
Signature of Patient or Legal Representative Signature of Witness

_____ _____
Date Date

Name of Privacy Officer for James T. Gardiner Family Dentistry, P.C. dba Singing River Dentistry Dr. James T. Gardiner
Address: 121 E. 6th St., Tuscumbia, AL 35674
Phone: (256) 383-0377 **Fax:** (256) 383-0745 **Email:** gardinerdental@gmail.com

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name:_____

Patient's Birth Date:_____ Patient's Social Security #:_____

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment,** various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting us.

You have the right to revoke your Consent by giving written notice to us. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this **Consent Form** after you have signed it.

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Dr. James T. Gardiner
Address: 121 E. 6th St., Tuscumbia, AL 35674
Phone: (256) 383-0377 **Fax:** (256) 383-0745 **Email:** gardinerdental@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I, _____, acknowledge that I have received a copy of this office's Notice of Privacy Practices. I have read the contents of the Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Print Patient's name or Representative's name here Patient's Signature or Representative's Signature here

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

___ The patient refused to sign.
___ Due to an emergency situation, it was not possible to obtain an acknowledgement.
___ We weren't able to communicate with the patient.
___ Other (Please provide specific details)

_____
_____
_____

_____ _____
Employee Signature Date

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *(insert date)* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. James T. Gardiner. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

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121 E 6th Street
Tuscumbia, AL 35674-2413
(256)383-0377

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please list all medications you are currently taking:

Are you diabetic? If so, what is your most recent A1C?

Do you have asthma?

◯ Yes ◯ No

Are you currently taking bloodthinners?

◯ Yes ◯ No

Do you now or have you ever taken osteoporosis (bone strengthening) medications?

◯ Yes ◯ No

Are you allergic to any medications?

◯ Yes ◯ No

If so, please list any medications you are allergic to.

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Who is your primary care doctor and when did you last see them?

Do you see a Specialist for any reason? If so please list Name and phone number.

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Please mark any of the following to indicate Yes in response to the question:

- ☐ Do you have any artificial joints, joint replacements or heart valve replacements?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco-smoking or smokeless(chewing)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

Do you currently use CPAP? If so, for how long?

Do you have any joint replacements, heart valve replacements or artificial joints? If so please give date performed.

WOMEN ONLY: Are you pregnant or nursing? If pregnant when is your due date?

When was your last visit to the dentist (if to a different office)?

Please indicate if you have experienced any of the following:

☐ Autism Spectrum Disorder	☐ Developmental Delay	☐ Cancer
☐ Excessive bleeding	☐ HIV	☐ Heart valve replacement
☐ Milk allergies	☐ Dye allergies	☐ Epilepsy
☐ Hepatitis	☐ Rheumatic Fever	☐ Stomach Problems/Ulcers
☐ Thyroid Disorder	☐ Migraines or headaches	☐ Chemotherapy/Radiation
☐ Lung disease/COPD	☐ Heart disease	☐ High Blood Pressure
☐ Stroke	☐ Insomnia	☐ Mental Disorder
☐ Frequent Urination at Night	☐ Overweight	☐ Diabetes

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The core values of SRD are centered around our patients' total health. The next few questions are related to your sleep. They will help us assess your risk for sleep apnea, which research shows causes multiple issues affecting your total health.

What are the chances of you dozing off in the given situation?

while sitting and reading?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

while watching TV?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

while sitting or inactive in a public place (meeting, theatre)?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

as a passenger in a car for an hour without a break?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

lying down to rest in the afternoon?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

sitting and talking to someone?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

sitting quietly after lunch without alcohol?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

while stopped for a few minutes at a traffic light?

◯ No chance ◯ Slight Chance ◯ Moderate Chance ◯ High Chance

Please mark any of the following to indicate Yes in response to the question:

☐ Do you often feel tired, fatigued, or sleepy during the day?

☐ Do you snore often (3 or more nights a week)?

☐ Do you snore loudly (ie, louder than talking or loud enough to be heard through closed doors)?

☐ Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?

☐ Is your neck 17 inches or greater for men (16 inches for women)?

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Do you have any other health issues or allergies?

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

☐ TMJ or Jaw pain

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

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☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

Staff Initials:

Response Date: 5/3/2018