

PATIENT NAME _____

DATE _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe _____ Yes No
Do you have dental examinations on a routine basis? Last visit _____ Yes No
Do you think you have active decay or gum disease? _____ Yes No
Do you brush and floss on a routine basis? Discuss _____ Yes No
Do your gums ever bleed? Discuss _____ Yes No
Do you like your smile? Why? _____ Yes No
Does food catch between your teeth? Any loose teeth? _____ Yes No
Do you want to keep your remaining teeth? _____ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? _____ Yes No
Have your past experiences in a dental office always been positive? _____ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss _____ Yes No
Name of previous dentist (optional): _____
Date of last full mouth x-rays (16 small films or panoramic): _____

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Have you ever had a serious injury to your head or neck? Discuss _____ Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No
Are you on a special diet? Discuss _____ Yes No
Are you allergic to any medications or substances? Please check box below _____ Yes No
[] Aspirin [] Penicillin [] Codeine [] Acrylic [] Metal [] Latex Rubber [] Milk [] Other _____
Women (Please check): [] Pregnant/trying to get pregnant [] Nursing [] Taking oral contraceptives Discuss _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

Table with 12 columns: Condition (Yes/No), Excessive Bleeding (Yes/No), Chemotherapy (Yes/No), Night Sweats (Yes/No), Cold Sores (Yes/No), Heart Murmur or Defect* (Yes/No), Sickle Cell Disease (Yes/No), Osteoporosis (Yes/No), Yellow Jaundice (Yes/No), Fever Blisters (Yes/No), Irregular Heart Beat (Yes/No), Hemophilia (Yes/No), Bisphosphonates (Yes/No), Kidney Problems (Yes/No), Herpes (Yes/No), Angina/Chest Pain (Yes/No), Methemoglobinemia (Yes/No), Osteonecrosis of Jaw (Yes/No), Renal Dialysis (Yes/No), Stroke (Yes/No), Heart Attack/Failure (Yes/No), Leukemia (Yes/No), Aredia I.V. Reclast I.V. (Yes/No), Thyroid Disease (Yes/No), Convulsions (Yes/No), Congenital Heart Disorder* (Yes/No), Recent Blood Transfusion (Yes/No), Zometa I.V. (Yes/No), Parathyroid Disease (Yes/No), Epilepsy or Seizures (Yes/No), Mitral Valve Prolapse* (Yes/No), Swelling of Limbs (Yes/No), Fosamax, Actonel, Boniva (Yes/No), Arthritis/Gout (Yes/No), Fainting or Dizziness (Yes/No), Scarlet Fever (Yes/No), Lung Disease (Yes/No), Stomach/Intestinal Disease (Yes/No), Rheumatism (Yes/No), Glaucoma (Yes/No), Rheumatic Fever* (Yes/No), Breathing Problem (Yes/No), Ulcers (Yes/No), Pain in Jaw Joints (Yes/No), Tumors or Growths (Yes/No), Artificial Heart Valve* (Yes/No), Shortness of Breath (Yes/No), Recent Weight Loss (Yes/No), Cortisone Medicine (Yes/No), Nervousness (Yes/No), Heart Pace Maker* (Yes/No), Frequent Cough (Yes/No), Frequent Diarrhea (Yes/No), Artificial Joint* (Yes/No), Psychiatric Care (Yes/No), Pulmonary Shunt* (Yes/No), Hay Fever (Yes/No), Diabetes (Yes/No), Sexually Transmitted Disease (Yes/No), Alzheimer's Disease (Yes/No), High Blood Pressure (Yes/No), Sinus Trouble (Yes/No), Excessive Thirst (Yes/No), AIDS (Yes/No), Allergies (Medicines) (Yes/No), Low Blood Pressure (Yes/No), Asthma (Yes/No), Hypoglycemia (Yes/No), HIV Positive (Yes/No), Allergies (Pollen / Dust) (Yes/No), Bacterial Endocarditis* (Yes/No), Bloody Sputum (Yes/No), Liver Disease (Yes/No), Genital Herpes (Yes/No), Hives or Rash (Yes/No), Unexplained Fever (Yes/No), Emphysema (Yes/No), Hepatitis A (Infectious) (Yes/No), Drug Addiction/Alcoholism (Yes/No), Need Premedication? (Yes/No), Bruise Easily/Blood Disease (Yes/No), Tuberculosis (Yes/No), Hepatitis B or C (Yes/No), Tattoos/Body Piercing (Yes/No), Ever taken fen-phen?* (Yes/No), Anemia (Yes/No), Cancer (Yes/No), Hepatitis B or C (Yes/No), Sleep Apnea (Yes/No), Cochlear implants? (Yes/No), Coronary Stent* (Yes/No), X-Ray Treatments (Radiation) (Yes/No), Protease Inhibitor (Yes/No)

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with 5 columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, PULSE, REVIEWED BY. Contains 5 rows for tracking updates.

PATIENT INFORMATION

DATE _____

NAME _____ MARRIED SINGLE MINOR MALE FEMALE
LAST FIRST M

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME# WORK# FAX# *cell #* E-MAIL#

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: PATIENT GUARDIAN SPOUSE FATHER MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
 ADULTS - COMPLETE PRIMARY INSURED
 DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY				SECONDARY INSURED			
LAST	FIRST	M		LAST	FIRST	M	
STREET	CITY	STATE	ZIP	STREET	CITY	STATE	ZIP
HOME #	WORK#	FAX#	E-MAIL#	HOME #	WORK#	FAX#	E-MAIL#
BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT		BIRTHDATE (MO/DAY/YEAR)		RELATIONSHIP TO PATIENT	
EMPLOYER		DENTAL INS. CO		EMPLOYER		DENTAL INS. CO	
SS#	SUBSCRIBER #	GROUP #		SS#	SUBSCRIBER #	GROUP #	

PERSON TO CONTACT IN CASE OF EMERGENCY

Outside of Immediate Family Household
 Name _____
 Address _____
 City/State/ZIP _____
 Telephone # _____

Has any member of your family ever been treated in our office?

Yes No

Whom may we thank for referring you to our office?

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
 Patient or Responsible Party

 Date State Driver's License #

METHOD OF PAYMENT

Responsible party currently has an account with this office

Yes No

Payment in full at each appointment (cash or personal check)

Payment in full at each appointment (VISA MC OTHER)

Card # _____ Exp. Date _____

I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within 25 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 \$3.00 for a balance under \$200.00) which is an annual percentage rate of 18% applied to the last month's balance. In the 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 or future outstanding accounts.

Jeffrey W. Timm, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, 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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Timm Family Dentistry
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.

*If you have any questions about this notice, please contact the designated privacy officer
of our office at 541-382-1991
375 NE Emerson Ave
Bend, OR 97701*

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your physician.

This notice is intended to inform you of how we protect, use and disclose your information, as well as to explain your right to control these disclosures.

Your Health Information

We may use and disclose health information about you without your permission for the following purposes:

1. We may disclose your information for **treatment purposes and to coordinate your medical care.**
2. We may disclose your information **to ensure that you receive insurance benefits.**
3. We may disclose your information internally **to enhance the operation of our practice.** This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information **to comply with a limited number of legal requirements,** as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. In any case, we will only disclose the minimum amount of information necessary for the purpose it was requested.

Effective Date: March 23, 2013

Our Duties

We are required by law to keep your information private. We must also provide you with this Notice and abide by its terms. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our Notice of Privacy Practices and to make the new terms effective for all information covered by our Notice. If such changes occur, we will let you know about the new terms by providing a copy of the changes.

Your Privacy Rights

Please note that you are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our designated contact in order to inspect and/or copy your information. If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other associated supplies. You may also choose to receive a copy of your health information in electronic form.

We may deny your request to inspect and/or copy information in certain limited circumstances. If you are denied access to your health information, you can ask that the denial be reviewed. If the law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

Right to Amend

If you believe our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and can decline to amend the record. We are required to place a copy of your proposed amendment in the record, even when we do not agree to amend the record itself.

We may deny your request for an amendment if we did not create the information, unless the person or entity that created the information is no longer available to make the amendment.

Right to Request Restrictions

You have the right to request restrictions on the use and disclosure of your information. We are not required to agree to your request. If we do agree, we will comply to the best of our ability unless the information is needed to provide you with emergency treatment. To request restrictions, you may complete and submit the **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. If your restriction invalidates your insurance coverage, we may require you to execute a waiver of insurance benefits and a payment agreement.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the form **Request for Restriction on Use/Disclosure of Medical Information** to our designated Privacy Officer/Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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 copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our designated Privacy Officer/Contact.

Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

To obtain this list, you must submit your request in writing to our designated Privacy Officer/Contact. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list (for example, on paper or electronically).

The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Complaints and Investigations

We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information.

You may also contact our on-site Privacy Officer/Contact, who is dedicated to investigating complaints regarding the use and disclosure of information in our care. We will not, and legally cannot, retaliate against you for any complaint.

Types of Use and Disclosure of Your Protected Health Information

We may disclose your information for the following purposes without your consent:

For Treatment Purposes

We may disclose information needed for the provision, coordination or management of health care and related services, including the coordination between our office and a third party, such as a consultation between medical providers or a referral from our office to another provider. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other health-care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment

To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility for coverage and adjudication of claims, billing, claims management and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness or justification of our charges.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. You have the right to restrict disclosures of your PHI to a health plan if you have paid out-of-pocket in full for the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. Healthcare operations may include:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals or evaluating practitioner and provider performance
- Conducting training programs, accreditation, certification, licensing or credentialing activities
- Arranging for or conducting medical review, legal services or auditing functions, including fraud and abuse detection and compliance programs
- Managing and operating our practice, including activities such as customer service and complaint resolution

Appointment Reminders

We may contact you (via voicemail messages, postcards or letters) as a reminder that you have an appointment for your treatment or medical care at our office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you. We also may tell you about health-related products or services that may be of interest to you.

Marketing Health-Related Services

We will not use your health information for marketing communications without your written, prior authorization. We will not sell your PHI to another organization for marketing or any other purposes.

Special Situations

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
3. **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
4. **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
5. **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
6. **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
7. **Public Health Risks.** We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
8. **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
9. **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
10. **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
11. **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.
12. **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
13. **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.
14. **Deceased Person's PHI** may be disclosed by our practice to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

Other Uses and Disclosures of Health Information

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time.

If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*. However, we cannot take back any uses or disclosures already made with your permission.

You have the right to be notified following a breach of your PHI by our practice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact:

Timm Family Dentistry
375 NE Emerson Ave
Bend, OR 97701
541-382-1991

You will not be penalized for filing a complaint.

Financial Agreement and Office Policy

Please review the following carefully, then sign and date the bottom of this agreement once you have reviewed it and understand it fully.

Payment is due at the time dental treatment is performed.

- ◆ Payment made by check or cash for the full amount of treatment will be given a 5% discount.
- ◆ We accept Visa, MasterCard and American Express.
- ◆ If you have dental insurance, as a courtesy to you, we will submit you insurance claim electronically for processing. We will *estimate* your insurance carriers portion and the guarantors portion due by you at the time of service. Should your insurance carrier pay less than the estimated amount, you will be billed for that balance and it will be payable upon receipt.
- ◆ Financing options are available through American General or CareCredit financing and must be secured in advance of treatment. Brochures and applications are available at the front desk. You can also apply for CareCredit on line at carecredit.com. Please don't hesitate to ask if you have questions or would like an application.

Appointment Scheduling is a critical part of our day. With that in mind, we require at least two working days notice to cancel or move a scheduled appointment. We make every effort to provide appointment cards and reminder phone calls for our patients so that they are informed of the next appointment they have scheduled. Cancellations or missed appointments without the two working days notice will be charged a \$25.00 appointment fee. **Initial**_____

By signing this agreement you understand and agree to the policies of this office. Furthermore, you understand that we do our best to estimate treatment and its cost and that final treatment is determined upon the completion of dental work.

Insurance benefits can only be ESTIMATED. A written pre-estimate/authorization of dental benefits from your insurance carrier is not a guarantee of payment. Please refer to your carrier handbook for specifics on benefit coverage for your plan. Costs not covered by your insurance carrier become the immediate responsibility of the guarantor.

Timm Family Dentistry is NOT responsible for the collection of dental insurance benefits but that claims will be as a courtesy to the patient. We make every attempt to ensure the accuracy of your dental claim based on the information provided by each patient. It is the patients' responsibility to update carrier information, as changes become necessary. You understand that all costs not paid by your insurance carrier are the responsibility of the guarantor and due within 30 days. A finance charge of 1.5% per month or 18% per year will be added to all accounts over 60 days regardless of insurance coverage. I agree to pay that finance charge.

In the event that legal or collection action becomes necessary, I further agree to pay ALL legal, collection and/or court costs involved.

Date: _____ Signature: _____

Date: _____ Agent for Dr. Timm: _____