HOTT
FAMILY DENTISTRY

706 N. Main St.
Bluffton, IN 46714
(260) 824-2442
blufftondentaldds@gmail.com
www.hottfamilydentistry.com

PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date_____/_____/_____

Patient's Name _____
LAST FIRST MI

Patient's Address: Street, Apt # _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Ext _____ Cell Phone # _____

E-mail _____ Marital Status: ❒Single ❒Married ❒Minor ❒Other Best time to call: _____

Spouse's Name _____ Do you have children? ❒Yes ❒No / How many? _____

Social Security # _____ ❒Male ❒Female Age _____ Date of Birth _____
MONTH / DAY / YEAR

Patient Employer/School _____ How Long? _____ Occupation _____

Employer/School: Street _____ City _____ State _____ Zip _____ Phone # _____

Referred by: ❒Radio ❒Newspaper ❒Phonebook ❒Website ❒Social Media ❒Friends or Family _____

INSURANCE

Primary Dental Insurance Company Name _____ Phone # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insured's Name _____ Policy # _____ Group # _____

Relation to Patient _____ Insured's Employer _____ Date of Birth _____
MONTH / DAY / YEAR

Secondary Dental Insurance Company Name _____ Phone # _____

Insurance Company Address _____ City _____ State _____ Zip _____

Insured's Name _____ Policy # _____ Group #

Relation to Patient _____ Insured's Employer _____ Date of Birth _____
MONTH / DAY / YEAR

EMERGENCY

Emergency Contact Name _____ Relation _____

Home Phone # Work Phone # _____ Cell Phone # _____

Who is your Medical Doctor? _____ Doctor's Phone # _____

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DENTAL & MEDICAL INFORMATION

DENTAL HISTORY

Reason for today's visit? ❒Exam ❒Emergency ❒Consultation Are you in pain? ❒Yes ❒No How long?_____

Please indicate ☑ any of the following problems:

❒Discomfort, clicking or popping in jaw	❒Lost/broken filling(s)	❒Stained teeth
❒Red, swollen or bleeding gums	❒Teeth grinding	❒Locking jaw
❒Sensitive tooth, teeth or gums	❒Ringing in ears	❒Bad breath
❒Blisters/sores in or around mouth	❒Broken/chipped tooth	

Other:_____

Do you require pre-medication? ❒Yes ❒No ❒Don't know

Previous Dentist_____Last Dental exam___/___/___Last Dental X-rays___/___/___

Times a day you brush?_____Times a week you floss?_____Type of tooth brush bristles you use ❒Soft ❒Medium ❒Hard

How would you rate your smile? (worst) ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10 (best)

MEDICAL HISTORY

What medications are you taking? ❒Nerve pills ❒Pain killers (including aspirin) ❒Muscle relaxers ❒Stimulants ❒Insulin ❒Blood thinners ❒Tranquilizers ❒Osteoporosis Medication ❒Other(s)_____

Have you ever taken: Bisphosphonates (e.g. Aredia/Fosamax) ❒Yes ❒No Phen-fen/Redux ❒Yes ❒No

Do you have, or have you had any of the following diseases, medical conditions or procedures?

❒Yes ❒No Heart attack/stroke	❒Yes ❒No Thyroid problems	❒Yes ❒No Cancer/tumors	❒Yes ❒No Cosmetic surgery
❒Yes ❒No Heart surgery/pacemaker	❒Yes ❒No Kidney problems	❒Yes ❒No Shingles	❒Yes ❒No -X-ray/Cobalt treatment
❒Yes ❒No Heart murmur	❒Yes ❒No Liver problems	❒Yes ❒No Hepatitis	❒Yes ❒No Chemotherapy
❒Yes ❒No Rheumatic fever	❒Yes ❒No Respiratory problems	❒Yes ❒No HIV+/AIDS/ARC	❒Yes ❒No Asthma
❒Yes ❒No Mitral valve prolapse	❒Yes ❒No Sinus problems	❒Yes ❒No Arthritis/rheumatism	❒Yes ❒No Difficulty breathing
❒Yes ❒No Artificial valves	❒Yes ❒No Stomach problems/ulcers	❒Yes ❒No Artificial bones/joints	❒Yes ❒No Diabetes/hypoglycemia
❒Yes ❒No Heart disease	❒Yes ❒No Psychiatric problems	❒Yes ❒No Emphysema	❒Yes ❒No Leukemia
❒Yes ❒No Congenital heart defect	❒Yes ❒No Venereal disease	❒Yes ❒No Fainting/seizures/epilepsy	❒Yes ❒No Anemia
❒Yes ❒No Chest pains	❒Yes ❒No Alcohol/drug abuse	❒Yes ❒No Severe/frequent headaches	❒Yes ❒No High/low blood pressure
❒Yes ❒No Scarlet fever	❒Yes ❒No Tuberculosis TB	❒Yes ❒No Frequent neck pain	❒Yes ❒No Bleeding problems
❒Yes ❒No Nervousness	❒Yes ❒No Jaw problems TMJ/TMD	❒Yes ❒No Back problems	❒Yes ❒No Glaucoma

Please list any other surgeries or medial conditions you have had_____

Are you allergic to any of the following? ❒Latex ❒Penicillin/Amoxicillin ❒Tetracycline ❒Aspirin ❒Dental Anesthetics

❒Foods_____❒Others_____

Do you use tobacco ❒No ❒Yes/how used?_____How much?_____How long?_____

Please rate your general health from 1-10 (10 is best)_____Do you wear contact lenses? ❒Yes ❒No

Do you take birth control pills? ❒Yes ❒No Are you pregnant? ❒Yes ❒No If yes, how long? Are you nursing? ❒Yes ❒No

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ACCOUNT INFORMATION / AUTHORIZATION

PAYMENT INFORMATION

Person responsible for account

Name_____ Relation to Patient_____

Billing Address: Street, Apt #_____ City_____ State_____ Zip _____

Home Phone #_____ Work Phone #_____ Ext_____ Cell Phone #_____

Payment Method ❒Cash ❒Credit Credit Card #_____ Expiration____/____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Signature X_____ Date_____

AUTHORIZATION

We invite you to discuss with us any questions regarding our services.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I acknowledge that I have received a copy of the Notice of Privacy Practices

Signature X_____ Date_____

❒Adult Patient ❒Parent or Guardian ❒Spouse

OFFICE USE

Initials_____ Date_____ Comments_____

Initials_____ Date_____ Comments_____

Initials_____ Date_____ Comments_____

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Patient Acknowledgment and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____
Patient Signature Patient Name (please print)

I am also signing for my minor children: _____
(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____
Patient Signature Patient Name (please print)

I am also signing for my minor children: _____
I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____
(please print names)

_____

_____

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____
Office Personnel (signature) Office Personnel (print name)

Date: _____

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.

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. This Act gives you, the patient, significant new rights to understand and control how your health 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 only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill 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.

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.

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 (Chelsea Pursifull):

- 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 to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April, 2003 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 Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of 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.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

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