Patient Information

Patient's Name: _____

Address: _____

Birthdate: _____ **Social Security #** _____-____-_____ **Preferred Contact:** _____

Home Phone: _____ **Cell:** _____ **E-mail:** _____

Who can we thank for referring you to our office? _____

Responsible Party Information

Name: _____ **Circle One:** Single Married Other
LAST FIRST MIDDLE

Residence: _____
STREET CITY STATE ZIP

Mailing Address: _____
(If different) STREET CITY STATE ZIP

How long at this address? _____ **Home Phone:** _____ **Cell:** _____

Previous Address (if less than 3 yrs.) _____
STREET CITY STATE ZIP

Social Security # _____-____-_____ **Birthdate:** _____ **Relationship to Patient:** _____

Your Employer: _____ **Occupation:** _____ **No. Years Employed:** _____

Spouse's Name: _____ **Relationship to Patient:** _____

Spouse's Employer: _____ **Occupation:** _____ **No. Years Employed:** ____

Spouse's Social Security # _____-____-_____ **Birthdate:** _____ **Phone #** _____

Insurance Information

Subscriber/Insured's Name: _____ **Insurance ID #** _____

Insurance Company: _____ **Do you have secondary insurance? YES or NO**

Other/Secondary Insurance Info:

Emergency Contact

Name of nearest relative: _____ **Relationship:** _____

Complete Address _____ **Phone:** _____

I authorize release of any information necessary for the filing of insurance claims. I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

Signature of Patient/Responsible Party _____ **Date:** _____

Health History

(Circle One)

1. Are you having pain or discomfort at this time?..... YES NO
2. Do you feel very nervous about this dental treatment?..... YES NO
3. Have you ever had a bad experience in a dental office?.....YES NO
4. Have you been a patient in the hospital during the last two years?.....YES NO
5. Have you been under the care of a medical doctor during the past two years?
   Your Physician's Name:_____ YES NO
   Address:_____Phone:_____
   When was you last complete physical?_____
6. Have you taken any medication or drugs in the past two years?.....YES NO
   Are you currently taking any medication, drugs, or pills?.....YES NO
   If yes, please list:_____
7. Are you allergic or have you reacted adversely to any of the following medications?.....YES NO
   If yes, please circle:

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocan or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	(Nembutal-Seconal)	Other Antibiotics

8. Are you aware of being allergic to any other medications or substances?.....YES NO
9. Circle any of the following that apply to you now or in the past:

Heart Failure	Emphysema	A.I.D.S / HIV +
Heart Disease or Attack	Cough	Hepatitis A (Infectious)
Angina Pectoris	Tuberculosis(TB)	Hepatitis B (Serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease-
Heart Pacemaker	X-Ray or Cobalt Treatment	-(Syphilis, Gonorrhea)
Cold Sores	Heart Surgery	Chemotherapy-
Fever Blisters	Artificial Joints(Hip or Knee)	-(Cancer, Leukemia)
Arthritis	Epilepsy or Seizures	Anemia
Rheumatism	Fainting or Dizzy Spells	Stroke
Cortisone Medicine	Nervousness	Kidney Trouble
Glaucoma	Psychiatric Treatment	Ulcers
Pain in Jaw Joints	Sickle Cell Disease	Cosmetic Surgery

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath?.....YES NO
11. Do your ankles swell during the day?.....YES NO
12. Do you use 2 or more pillows to sleep?.....YES NO
13. Have you lost or gained more than 10 lbs. in the past year?.....YES NO
14. Do you ever wake up from sleep short of breath?.....YES NO
15. Are you on a special diet?.....YES NO
16. Has your medical doctor ever said that you have cancer or a tumor?.....YES NO
17. Do you have any disease, condition, or problem not listed?.....YES NO
    If yes, please explain:_____

FOR WOMEN ONLY: Are you pregnant? ☐ YES ☐ NO If yes, what month?_____
Are you taking birth control? ☐ YES ☐ NO

THE ABOVE INFORMATION IS TRUE.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand that use of anesthetic agent embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine and due and payable at the time services are rendered, unless financial arrangements have been made.

PATIENT/RESPONSIBLE PARTY SIGNATURE_____DATE:_____

Brian K. Dufner, D.M.D., P.A.

FINANCIAL POLICY

Thank you for choosing Brian K. Dufner DMD, PA. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options:

- **Cash**
- **Visa, Mastercard, Discover, American Express, and Apple pay**
  If you are paying with a credit card, your portion will be charged at the time the services are rendered (including Health Savings Accounts)
- **Care Credit**
  Allows you to make payments over time (12 no interest $200 and over or fixed APR 24 or 36 months on $1,000 and over). Plus, no annual fee or penalty for early pay off.

Dufner Family Dentistry requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patents with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance within 30 days, you will be responsible for the payment of your treatment fees and you will collect your benefits directly from your insurance carrier.

Dufner Family Dentistry charges $30 for any returned check. Any finance charge that has occurred due to non-payment is the responsibility of the patient/responsible party.

_____

Signature of Patient/Parent or Guardian

5830 SW Huntoon St.
Topeka, KS 66604
Phone (785) 232-1985
Fax (785) 232-1769

Brian K. Dufner, D.M.D., P.A.

Acknowledgement of Receipt of Privacy Practices Notice

I,_____,
acknowledge that I have
(Please print)

Received a copy of the Notice of Privacy Practice from the above-named doctor's office.

My dental record may be discussed with (check one):

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information may not be discussed with anyone (initial here)_____

This Release of information will remain in effect until terminated by me in writing.

_____

Signature (Patient/Parent/Guardian) Date

5830 SW Huntoon St.
Topeka, KS 66604
Phone (785) 232-1985
Fax (785) 232-1769

Brian K. Dufner, DMD, PA

Wisconsin Dental Association
(800) 243-4675

[Insert Name of Practice]

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: _____

Telephone: _____

E-Mail: _____

Address: _____

Brian K. Dufner D.M.D, P.A.
5830 SW Huntoon St
Topeka KS 66604
785-232-1985
dufnerfamilydentistry.com

DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES:

_____

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____
Delivery options ☐ mail ☐ delivery ☐ email ☐ fax ☐ pick up *(please fill in below)*

To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: _____
Name of Health Care Provider / Plan / Other/ Myself

_____
Address

PHONE: _____ FAX # _____

EMAIL : _____

Only information from the past five (5) years will be disclosed. Unless dates filled in below.
From: _____ *To* _____

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 yrs and treatment dates for prophy's (cleanings) – exams – scale & root planning. To send just this basic information described above please check here ☐

If you want us to release other information then please mark below.
INFORMATION TO BE DISCLOSED:
Treatment plan ☐ Radiology films/images ☐ All billing records ☐

Specific records/information as follows: _____

_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
_____

EXPIRATION: This Authorization is good for one year unless dates filled in below
From: _____ *To* _____

SIGNATURE OF PATIENT / LEGAL REP:

_____ DATE: _____
If signed by a person other than the patient, complete the following: Individual is: ☐ parent* legal guardian
☐ legally incompetent ☐ incapacitated deceased ☐ next of kin / executor of deceased

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by _____