MINTON
FAMILY DENTAL CARE P.C.

Today's Date_____

Name of
Patient_____Birthdate_____Age_____

Mailing Address _____

Home Phone _____ Cell Phone _____Work Phone _____

Email_____SS#_____

Patient Employed by_____ Position Held_____

Name of Spouse (Name of parent if patient is under 21)_____

Purpose of today's appointment_____

**********Insurance Information**********

Dental Insurance company _____

Name of Policy Holder_____ Policy Holder's SS#_____ Date of birth_____

Secondary Dental Insurance Company_____

Name of Policy Holder_____ Policy Holder's SS#_____ Date of birth_____

Policy Holder's Employer_____Phone_____

Please share with us who or what referred you to our practice.

_____

MINTON FAMILY DENTAL CARE PAYMENT POLICIES

- Our office requests that payment due from the dental services rendered to you and your dependants to be paid at the time of service. We will attempt to advise you of this estimate amount prior to treatment. If we do not provide you this information, please request it.
- Please note that if you have dental insurance and we are able to confirm your benefits, we will estimate your portions due and ask that you pay only the amount at the time of service. Insurance benefits will be sent directly to our office and will be applied to your account. If a balance is remaining after insurance is paid, you will be sent a statement of that amount due.
- Patients with a balance overdue by 30 days or more will be required to pay their overdue balance prior to scheduling any future appointments.

Payment Options

1. Cash / Check / Money Order
2. Visa/Mastercard/Discover Credit Cards and Debit
3. CareCredit
4. Smile Plan Discount Dental Plan

****In house financing is not available****

MINTON FAMILY DENTAL CARE APPOINTMENT POLICY

We take our schedule very seriously. We are committed to seeing our patients at their appointed time and we work very hard to make sure this happens. Unfortunately, last minute changes, missed appointments, and late arrivals not only prevent us from staying on schedule, but prevent others from being seen. In order to respect everyone's time, we request 48 work hour notice for appointment changes.

In the case that you do not show up for a scheduled appointment with no prior 48 work hour notice, several problems could arise: your treatment may not be able to be delivered in a timely manner, you may be charged a no-show fee, or you may be dismissed from the practice. Of course, we try very hard to make sure none of this happens. By using appointment cards, sending appointment reminders, and requesting confirmations, we attempt to make sure you are fully aware of your appointments and their importance.

AUTHORIZATION TO RELEASE INFORMATION

TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents, or others to call and request treatment and appointment information. Under HIPAA laws, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to family members, you must authorize this form. This consent form will not allow Minton Family Dental Care to release any other information to these family members. You will have to sign a separate form to release radiographs.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Minton Family Dental Care to release my information to the following individuals

Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

I, the undersigned, certify and acknowledge the following:

- I authorize this office to release any health information for the use of treatment, payment, and healthcare operations which includes insurance companies, specialists, and other health care providers and institutions.
- I am 18 years or older. If you are under 18, your parent or guardian must sign this form.
- I understand that x-rays and other diagnostic tests may be recommended and denial of these tests can result in undiagnosed and untreated oral conditions.
- I am the responsible party and assume responsibility for all the costs, regardless of insurance coverage.
- I will not capture **any photographs** with my **cell phone, tablet, iPad, and etc.** while in Dr. Jessica Minton's office or treatment rooms. Doing so could be a violation of HIPAA laws.
- I agree to reimburse the fees of any collection agency, which may be a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys fees, we incur in such collection efforts.
- I understand that dental insurance companies rarely cover 100% of all dental expenses.
- I have checked and know that my insurance company accepts Dr. Minton as a covered provider.
- I understand that dental treatment carries with it some statistical risks even when performed with the utmost care.
- I understand that appointment times are reserved specifically for me and that any necessary changes should be finalized **48 hours prior** to the original appointment or a late cancellation fee may be charged.
- I have accurately answered all the questions and have read all the above information.

In case of an emergency, who should be notified? Please list their phone number

_____

Signature: _____

Relationship to Patient_____

Print name _____

Medical Information

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Please circle yes or no:

- **Are you under a physician's care now?** Yes No

If yes _____

- **Have you ever been hospitalized or had a major operation?** Yes No

If yes _____

_____

- **Are you taking any prescription medicine, over the counter medicine, supplements, or vitamins?**

  Yes No

If yes _____

_____

_____

- **List any medications that you are allergic to**: _____

_____

_____

- **Do you use controlled substances?** Yes No

If yes _____

- **Do you take, or have you taken, Phen-Fen or Redux?** Yes No
- **Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?** Yes No
- **Are you on a special diet?** Yes No
- **Do you use tobacco?** Yes No

  If yes, what type? _____
- **Do you object to the use of Nitrous Oxide?** Yes No
- **Have you ever required antibiotics before having your teeth cleaned?** Yes No
- **Have you ever had problems with local anesthesia (numbing your teeth)** Yes No
- **Have you had serious problems associated with dental treatment?** Yes No

Women: Are you…

Pregnant/Trying to get pregnant? Yes No

Nursing? Yes No

Taking oral contraceptives? Yes No

Do you have, or have you had, any of the following? Please Circle

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/ Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Trouble/Disease	Psychiatric Care	Venereal Disease

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient's Name_____

Signature (Patient or Guardian)_____

Date _____

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PATIENT APPOINTMENT AGREEMENT

We welcome you to our practice and greatly appreciate the opportunity to be your oral healthcare provider. We recognize that in today's busy world, adhering to our schedule is important for you to meet the time demands of your schedule. With this in mind, we have developed an appointment policy that will keep us on our schedule and, therefore, you on your schedule.

We are committed to seeing our patients at their appointment time, and we work very hard to make that happen. Late cancellations, missed appointments, and late arrivals cause us to run behind schedule in a variety of ways; therefore, to respect everyone's time, we ask you to adhere to the following:

1. IF YOU MUST MAKE AN APPOINTMENT CHANGE: Let us know no less than 2 workdays of notice for any necessary appointment changes you must make.

2. IF YOU FAIL TO COME TO YOUR APPOINTMENT: If you do not show up for your scheduled appointment, you may be charged a no-show fee and/or asked to confirm future appointments with a credit or debit card.

3. IF WE DO NOT RECEIVE AN APPOINTMENT CONFIRMATION FROM YOU: We must receive an appointment confirmation from you by phone, text, email, or in person. If we have been unable to receive a confirmation appointment from you 48 hours before your appointment, your appointment may need to be rescheduled or moved.

Thank you for your help in assisting us to care for you in a timely manner. We look forward to working together to achieve the goals that you have for your smile and your oral health.

Thank you,

Minton Dental

I hereby acknowledge that I have read and understood the Minton Family Dental Care Appointment Policy and that I agree with the terms:

_____ _____

Signature *Date*

_____ *(Relationship to patient)*

MINTON
FAMILY DENTAL CARE P.C.

CONSENT TO TREAT MINOR WITHOUT PARENT/LEGAL GUARDIAN PRESENT

Patient's Full Name: _____

DOB: _____

To allow for the treatment of patients who are considered minors, a parent or legal guardian must give consent for treatment. If a minor child presents to our practice without a parent or legal guardian or a signed consent form from the parent or legal guardian, treatment may be denied.

This consent form serves as permission for treatment by _____ for the above-named minor.

I _____ (name of parent or legal guardian) give my authorization for all dental treatment including regular preventive procedures during my absence which include: x-rays, exams, fluoride treatment, sealants, cleanings, and intraoral photos as well as an emergency dental treatment for the above-named child in the case of my absence.

Those people authorized to act in my behalf for my minor are:

1. name _____ cell _____

2. name_____cell_____

3. name_____cell_____

This authorization will remain in effect until I revoke this authorization in writing and submit it to our dental practice.

Parent/Legal Guardian Signature _____

Personal Cell number _____ Date _____

MINTON FAMILY DENTAL CARE

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

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/01/2010, 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 changes are permitted by applicable law. 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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 use 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.

Uses and Disclosures of Health Information
We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

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

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 obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We may charge you a reasonable cost-based fee for the cost of supplies and labor of copying.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled 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 the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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.

Contact Officer: Dr. Jessica Minton D.D.S.
Telephone: 423-626-7070
Address: 210 Cedar Fork Road, Tazewell, Tennessee 37879

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Jessica Minton's Notice of Privacy Practices.

Patient Name (Printed) _____

Signature _____

Date _____