



Patient Information Sheet

Date: _____
Chart ID: _____ Whom may we thank for referring you? _____
First Name: _____ Driver License: _____
Last Name: _____ SSN: _____
Middle Initial: _____ Preferred Name: _____
E-mail: _____ Gender: Male Female
Please circle: Marital Status: S M D W
Address: _____ City: _____ State: _____ Zip : _____
Home Phone: _____ Cell : _____
Employer: _____ Work Phone: _____ Ext: _____
Person is: Patient Policy Holder Responsible Party

Primary Dental Insurance:

Policy Owner: _____
DOB Policy Holder: _____
Relationship to Patient: _____
Policy Holder Address: _____
City: _____ State: _____ Zip: _____

Secondary Dental Insurance:

Policy Owner: _____
DOB Policy Holder: _____
Relationship to Patient: _____
Policy Holder Address: _____
City: _____ State: _____ Zip: _____

Do you receive e-mail correspondence? Yes No
Do you have insurance? Yes No

Do you receive text messages? Yes No
Are you the patient: Yes No

Responsible Party Guarantor Information: Same as Patient

First Name: _____ Mid: _____ Last Name: _____
SSN: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip : _____
Home Phone: _____ Cell : _____

PLEASE READ THE FOLLOWING VERY CAREFULLY

ASSIGNMENT OF BENEFITS AND GUARANTEE OF ACCOUNT: I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility. I, the undersigned, accept the fee charges as legal and lawful debt and agree to pay said fee, including any/all cost of collection. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other state. Any unpaid balance after insurance pays is due within 30 days. Balances older than 30 days will be subject to interest charges of 1.5% per month or 18% annually.

To service your account or to collect monies you may owe, Reeves Cosmetic Dentistry and/or our agents may contact you via telephone at any number associated with your account, which could result in charges to you. We may also contact you by sending a text message or email using any email address you provide us.

Patient/Guarantor Signature: _____ **Date:** _____

Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information

My signature below is acknowledgment that a copy of Reeves Cosmetic Dentistry's Privacy Notice has been made available to me and that I agree to the conditions stated in the notice: Patient Signature: _____ Date: _____

I hereby authorize Reeves Cosmetic Dentistry to use, disclose health information and financial information as follows:

Release to Name: _____ Relation to Patient: _____
Release to Name: _____ Relation to Patient: _____



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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect 10/01/14 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. 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, conducting training programs, and licensing activities.

Individual Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Teaching & Educational Purposes. We may use your health information for teaching or educational purposes. We will not disclose your name, address or other personal information, only the clinical aspects of your case.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;

- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official 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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations,

and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), had paid our practice 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law. **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 if 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. Please contact us if you have any additional questions or concerns:

Telephone: (205) 991-9997, Fax: (205) 991-9925,
Email: info@toodreevesmd.com

Mailing Address:

Reeves Cosmetic Dentistry
8040 Hugh Daniel Drive
Birmingham, AL 35242



Reeves Cosmetic Dentistry
AT GREYSTONE

Patient Name: _____ Date Of Birth: _____ Date Created: _____

DENTAL HISTORY

Reason for today's visit? _____

Former dentist: _____ Phone (_____) _____

Date of last dental care: _____ Date of last dental X-Rays: _____

Please put a check in the box if you have had problems with any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or fillings | <input type="checkbox"/> Sensitivity when chewing |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Teeth sensitivity to cold or heat | <input type="checkbox"/> Do you breathe through your mouth while awake or asleep |
| <input type="checkbox"/> Smoke / Chew tobacco | <input type="checkbox"/> Bite lips or cheeks regularly | |

How often do you floss? _____ How often do you brush? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical procedure? Yes No

Is there any more information about your dental health or previous treatment?

AUTHORIZATION

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's) health. It is my responsibility to inform the dental office of any changes in medical status.

I have reviewed the information of this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and helpful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all the insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. Insurance is also filed and accepted as a courtesy.

I authorize the dentist to release all information that is necessary to secure the payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Please note that accounts over 30 days old are considered past due and are subject to a 1.5% finance charge monthly. Dr. Reeves, at his discretion, may place the unpaid account with an attorney for collection. In the event an account is turned over to an attorney, the patient or person responsible for the patient's account agrees to pay an attorney fee, court costs and any other reasonable costs of collection.

Signature of Patient, Parent or Guardian: _____ DATE: _____

TURN OVER AND CONTINUE

MEDICAL HISTORY

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 medications that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physicians care now? Yes No If yes: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes: _____
- Have you ever had a serious back or neck Injury? Yes No If yes: _____
- Are you taking any medications, pills or drugs? Yes No If yes: _____
- Do you take, or have you taken Phen-Fen or Redux? Yes No If yes: _____
- Have you ever taken Fosamax, Boniva, Actonel,
or any other medications containing bisphosphonates? Yes No If yes: _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Women: Are you ...Pregnant/trying to get pregnant Yes No • Nursing Yes No • Taking oral contraceptives Yes No

- Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics
 Other If Yes: _____

- Do you use a controlled substance? Yes No If yes: _____

Do you have, or have you had any of the following?:

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 medications that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

- | | | |
|--|--|---|
| AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Swelling Of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors Or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain In Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | |

- Have you ever had any serious illness not listed: Yes No If yes: _____

COMMENTS: _____

