D. Allen Reed, DMD
Cosmetic and Family Dentistry

DATE _____

(PLEASE PRINT) CONFIDENTIAL INFORMATION CELL _____

PATIENT NAME _____ BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CHECK APPROPRIATE BOX: ☐ ADULT ☐ MINOR ☐ MALE ☐ FEMALE MARITAL STATUS _____

PATIENT'S SOCIAL SECURITY # _____ PATIENT WISHES TO BE CALLED _____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Responsible Party

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

SOCIAL SECURITY # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

Dental Insurance Information

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ PHONE _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

Additional Dental Insurance Information? IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ PHONE _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

Please check the appropriate answer to the following:

	Yes	No
1. Regular dental care in the past?	❑	❑
2. Happy with appearance of teeth?	❑	❑
3. Chew comfortably on both sides of mouth?	❑	❑
4. Teeth usually sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting Pressure		
5. Jaws ever feel tired or ache?	❑	❑
6. Jaws click or pop?	❑	❑
7. Unusual/frequent pain in: ❑ Teeth ❑ Jaws ❑ Jaw Joints ❑ Ears		
8. Do you clench or grind your teeth?	❑	❑
9. Frequent headaches?	❑	❑
10. Do your gums bleed when brushing?	❑	❑
11. Do your gums ever feel tender or swollen?	❑	❑
12. Have you ever been told you have periodontal disease?	❑	❑
13. Have you worn braces?	❑	❑
14. Have you ever had an unpleasant dental experience?	❑	❑

CURRENTLY:

	Yes	No
1. Do you have pain or discomfort at this time?	❑	❑
2. Have you been a patient in the hospital during the past two years?	❑	❑
3. Have you been under the care of a medical doctor during the past two years? If "Yes," reason:_____ Physician's Name_____ Address_____ Telephone_____	❑	❑
4. Have you taken any medication or drugs during the past two years?	❑	❑
5. Are you now taking any medication, drugs, or pills? If yes, please list:_____	❑	❑
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? If yes, please list:_____	❑	❑

7. Indicate which of the following you have had or have at present. Check "Yes" or "No" to each item.

	Yes	No		Yes	No		Yes	No
A.I.D.S.	❑	❑	Diabetes	❑	❑	Kidney Trouble	❑	❑
Allergies or Hives	❑	❑	Drug Addiction	❑	❑	Liver Disease	❑	❑
Anemia	❑	❑	Emphysema	❑	❑	Mitral Valve Prolapse	❑	❑
Angina Pectoris	❑	❑	Epilepsy or Seizures	❑	❑	Nervousness	❑	❑
Arteriosclerosis	❑	❑	Fainting or Dizzy Spells	❑	❑	Pain In Jaw Joints	❑	❑
Arthritis	❑	❑	Glaucoma	❑	❑	Psychiatric Treatment	❑	❑
Artificial Heart Valve	❑	❑	Hay Fever	❑	❑	Radiation Therapy	❑	❑
Artificial Joints (Hip, Knee, etc.)	❑	❑	Heart Disease or Attack	❑	❑	Rheumatic Fever	❑	❑
Asthma	❑	❑	Heart Failure	❑	❑	Rheumatism	❑	❑
Blood Transfusion	❑	❑	Heart Murmur	❑	❑	Sickle Cell Disease	❑	❑
Bruise Easily	❑	❑	Heart Pacemaker	❑	❑	Sinus Disease	❑	❑
Cancer	❑	❑	Heart Surgery	❑	❑	Sleep Apnea	❑	❑
Cold Sores/Fever Blisters	❑	❑	Hemophilia	❑	❑	Stroke	❑	❑
Chemotherapy	❑	❑	Hepatitis A (Infectious)	❑	❑	Thyroid Problems	❑	❑
Chronic Cough	❑	❑	Hepatitis B (Serum)	❑	❑	Tuberculosis	❑	❑
Congenital Heart Disease	❑	❑	High Blood Pressure	❑	❑	Ulcers	❑	❑
Cortisone Medicine	❑	❑	H.I.V. Positive	❑	❑	Venereal Disease	❑	❑
						Yellow Jaundice	❑	❑

	Yes	No
8. Have you been told by your physician to be pre-medicated before dental treatment?	❑	❑
9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?	❑	❑
10. Do you have or have you had any disease, condition, or problems not listed? If yes, please list: _____	❑	❑

For Women Only

Are you pregnant? ❑ Yes, what month?_____ ❑ No Are you nursing? ❑ Yes ❑ No Are you taking birth control pills? ❑ Yes ❑ No

Consent

I understand the above consent information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. 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 the above named patient, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk.

Financial Arrangements

For your convenience we offer the following methods of payment. Please check the option which you prefer. Payment is due in full at each appointment.

❑ Cash ❑ Personal Check ❑ Credit Card: ____Visa ____MC

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default, I agree to waive my rights to personal exemptions as set forth in Alabama laws and promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note.

Patient_____ **Date**_____ **Witness**_____

Parent or Responsible Party_____ **Relationship to Patient**_____

Reed
DENTISTRY
"Creating Beautiful Smiles."

Allen Reed, DMD
2213 Cahaba Valley Drive
Birmingham, AL 35242
(205) 981-0000

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:

- 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.

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PATIENT CONSENT FORM

Allen Reed, DMD
2213 Cahaba Valley Drive
Birmingham, AL 35242
(205) 981-0000

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____