COLUMBIA CENTER FOR DENTISTRY

ALEXANDER STANLEY, DDS

INFORMATION FORM (Age 18+)

CONFIDENTIAL Today's Date _____ /_____ /_____

PATIENT Full (legal) Name _____

Name you go by _____ Date of Birth _____ /_____ /_____ SSN _____-_____-_____

Home Address _____ City _____ ST _____ Zip _____

BEST phone (_____)_____ ALT. phone (_____)_____ E-mail _____

EMPLOYER _____ Occupation _____

Employer Address _____ Work Phone (_____)_____

Who will be responsible for your account? _____ (PAYMENT EXPECTED AT TIME OF SERVICE)

RESPONSIBLE PARTY Name _____ Relation to Patient _____

Responsible Party Address _____ City _____ ST _____ Zip _____

Dental Insurance Company _____ Employer _____

POLICY HOLDER Name _____ Relation to Patient _____

Phone Number (_____)_____ Date of Birth _____ /_____ /_____ SSN _____-_____-_____

EMERGENCY CONTACT Name _____ Relation to Patient _____

Phone Number (_____)_____

Whom may we thank for referring you? _____

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ACQUAINTANCE FORM (Age 18+)

Patient's Name: _____ Date: _____

Are you having any pain, sensitivity, or discomfort with your teeth (hot, cold, sweets, biting pressure)?.....Y / N

Do your gums bleed or cause you pain when brushing and/or flossing?.....Y / N

Do you ever avoid any part of your mouth while chewing or brushing?.....Y / N

Are any of your teeth loose?.....Y / N

Are you aware of having bad breath or an unpleasant taste or odor in your mouth?.....Y / N

Have you ever been told you have gum disease?.....Y / N

Does food catch between or around your teeth?.....Y / N

Do you suffer from dry mouth?.....Y / N

Are you prone to sores in or around your mouth?.....Y / N

Do you use tobacco products?.....Y / N

Do you drink soda, juice, or sweetened beverages?.....Y / N

Are you dissatisfied with the appearance and/or color of your smile?.....Y / N

Are you dissatisfied with the alignment of your teeth (crowded, crooked, gaps)?.....Y / N

Do you want your smile to look better?.....Y / N

Is your mouth as healthy as it can be?.....Y / N

Do you want your mouth to be healthier?.....Y / N

Do you want your teeth to last your lifetime?..... Y / N

Are you concerned about the cost necessary to improve the appearance and health of your teeth?.....Y / N

Do you have any pain or problems with your jaws (popping, restricted opening, sore joints or muscles)?.....Y / N

Are you aware of clenching or grinding your teeth?..... Y / N

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

How long has it been since you have had a thorough dental examination? _____ Cleaning? _____

Have you had any dental x-rays in the last 12 months?.....Y / N

Name of previous dentist _____ City, ST _____ Date last seen? _____

Do you use any rinses or dental medications?.....Y / N

Have you had a bad experience at the dentist before?..... Y / N

Have you had orthodontic treatment (braces or Invisalign)?.....Y / N

Have you had your wisdom teeth removed?.....Y / N

Are you missing teeth (other than wisdom teeth)?.....Y / N

Do you have any specific requests, questions, or concerns?.....Y / N

Are you ready to begin any treatment you may need or want?.....Y / N

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PC:

PI:

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HEALTH HISTORY FORM

Patient's Name:_____ Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 will receive. Thank you for answering the following questions.

Name of Physician: _____ City/State: _____ Date of Last Physical: _____

Are you under a physician's care now? ☐Yes ☐No Explain:_____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No Explain:_____

Have you ever had a serious head or neck injury? ☐Yes ☐No Explain:_____

Are you taking any medications, pills, or drugs? ☐Yes ☐No Explain:_____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No Explain:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No Explain:_____

Do you use any tobacco products? ☐Yes ☐No Explain:_____

Do you use any controlled substances? ☐Yes ☐No Explain:_____

WOMEN: Are you… ☐Pregnant/trying to become pregnant? ☐Nursing? ☐Taking oral contraceptives?

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Sulfa Drugs

☐Other Explain:_____

Do you have, or have you ever had any of the following? (Check boxes that apply):

☐AIDS/HIV Positive	☐Cortisone Medication	☐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(s)	☐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/Intestine Disease
☐Breathing Problems	☐Frequent Headaches	☐Liver Disease/Jaundice	☐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 Pace Maker	☐Parathyroid Disease	☐Ulcers
☐Convulsions	☐Heart Trouble/Disease	☐Psychiatric Care	☐Venereal Disease

Have you ever had any serious illness not listed above? ☐Yes ☐No Explain:_____

Is there anything else we should know about your medical history? _____

_____

The above information is accurate and complete, to the best of my knowledge, and may be used for treatment and processing of insurance benefits to which I may be entitled. I will not hold any member of Columbia Center for Dentistry responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to inform the office of any changes in medical status and I further realize that undiagnosed medical conditions can adversely affect dental outcomes.

Signature of Patient, Parent or Guardian _____ Today's Date:_____

COLUMBIA CENTER FOR DENTISTRY

ALEXANDER STANLEY, DDS

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.
THIS 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 health information. We are also required 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 that are described in this Notice while it is in effect. This Notice takes effect 4/14/2003, 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 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 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 healthcare operations. For example:
Treatment: We may use or 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.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.
To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 notifications 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 incapacity or 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.

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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of 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).

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 requested 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.

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 from the date of your acknowledgement of this notice.

Restrictions: 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).

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). Your request must specify the alternative means or location, and provide satisfactory explanation 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: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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: Alexander Stanley, Business Manager
Telephone: (573) 446-2687 Fax: (573) 446-3685
Address: 4301 Rainbow Trout Drive, Suite 101, Columbia, MO 65203

COLUMBIA CENTER FOR DENTISTRY

ALEXANDER STANLEY, DDS

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

COLUMBIA CENTER FOR DENTISTRY

ALEXANDER STANLEY, DDS

Thank you for choosing Columbia Center for Dentistry. Our goal is to provide exceptional dental services and products in a comfortable, caring manner. We believe you expect us to understand and honor your individual needs and goals. So that we may serve you best, please read and initial the following office information and sign at the bottom.

APPOINTMENT RESERVATIONS

We schedule by appointment only. When you request an appointment we reserve that time exclusively for you and do not offer it to anyone else. If, for any reason, you are unable to honor your reservation we require at least 24 hours notice. We reserve the right to require a deposit to hold a reservation and charge for failed or cancelled appointments. **Initial: _____**

PAYMENT FOR SERVICES

You acknowledge that payment is due when services are rendered, and that parents/guardians are fully responsible for all fees incurred for treatment of their child. We accept cash, checks, debit cards, Visa, MasterCard, Discover, and American Express. We offer financing through CareCredit for those who qualify. Arrangements must be made before your appointment. Returned checks will be charged $25 and may be sent to the prosecuting attorney. Delinquent accounts will be charged interest and may be pursued by a collection attorney and charged legal fees and you are responsible for any costs associated with attempts to collect your debt. **Initial: _____**

DENTAL INSURANCE ASSIGNMENT OF BENEFITS

Dental insurance benefits rarely cover 100% of your services. Any amount not covered by or excluded from your plan is your responsibility and payable immediately. Furthermore, you accept responsibility for knowing the restrictions and exclusions of your policy. We do not guarantee insurance benefit estimates or coverage. We will file your primary claims as a courtesy; secondary claims are your responsibility. All reimbursement is the property of Columbia Center for Dentistry and must be surrendered to cover any outstanding balance on your account. By initialing and signing below you assign any and all insurance benefits, otherwise payable to you, to Columbia Center for Dentistry and authorize the use of your signature on all submissions, whether manual or electronic. Disputes regarding reimbursement are between the policyholder and the insurance plan provider. **Initial: _____**

RELEASE OF INFORMATION

I authorize the release of information from Columbia Center for Dentistry to insurance companies or other health care providers, whether manual or electronic, for any purpose deemed necessary. I further allow unrestricted use of photographs, radiographs, and technical information by Columbia Center for Dentistry. **Initial: _____**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have received a copy of Columbia Center for Dentistry's Notice of Privacy Practices (HIPAA regulations) and agree to its terms. **Initial: _____**

INFORMED CONSENT FOR TREATMENT

I consent to treatment by C. Bradley Miller, DDS, PC, and/or his designees. By allowing treatment, I acknowledge that I have requested the services be performed and have been fully informed of the benefits and risks of the procedure(s). I understand that dentistry is not an exact science and that unpredictable complications can occur and results cannot be fully guaranteed. Dental restorations wear out over time and need maintenance, replacement, or further treatment. I understand the importance of consistent, thorough home care and periodic professional treatment and the consequences of not pursuing treatment when recommended by Columbia Center for Dentistry. **Initial: _____**

I have read, and understand, and accept the information presented.

Print Name: _____ **Date: _____**

Signature: _____ **Witness: _____**