HOMEWOOD DENTAL ASSOCIATES

Today's Date_____

PATIENT INFORMATION

Patient's Last Name	First Name	Initial	Age	Sex	Date of Birth

Home Address	City	State	Zip Code	Home Phone Number

Employer Name and Address:	Occupation	Phone Numbers Work Cell	Social Security Number

Who referred you to this office?	Email Address	If Minor – Name of School

Marital Status	Spouse Name	Spouse Work Number	Children's Names and Ages

Spouse Employed By:	Occupation	Spouse Cell Number

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account			
Home Address (if different from Patient	City	State	Zip Code

Home Phone Number	Social Security Number	Drivers License Number

How would you like to pay for today's visit?
CASH_____ CHECK_____ CREDIT CARD_____

INSURANCE INFORMATION

Do You Have Dental Insurance?	
Name of Insured	Date of Birth
Name/Address of Primary Dental Insurance	Policy Number/Group Number
Name/Address of Secondary Dental Insurance	Policy Number/Group Number

OFFICE POLICIES

EMERGENCIES: All emergency services to be paid in cash.

APPOINTMENTS: A minimum charge will be made for broken or cancelled confirmed appointments without prior notification of 24 hours. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

DELINQUENT ACCOUNTS: I do hereby agree that payment is due when services are rendered, unless other payment arrangements have been made. Should my account become delinquent and require the services of an attorney or a collection agency for collection, I will pay all collection fees and/or a reasonable attorney's fee, as well as all court costs, which will be added to the original amount of the delinquent account. I also waive rights of exemption under the constitution and laws of Alabama or any other state as to personal property. All accounts over 60 days will be charged 1.5% interest. All accounts must be paid in 90 days to avoid collection procedures UNLESS FINANCIAL ARRANGEMENTS ARE MADE PRIOR TO TREATMENT.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

Signature:_____ **Date:**_____
(Parent or Guardian, if patient is a minor)

Time 8:51 AM

Homewood Dental Associates

Date 10/3/2018

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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.

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
Have you ever had a serious head 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? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problems ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X Date:_____

HOMEWOOD DENTAL ASSOCIATES

2045 Medical Center Drive, Suite 4, Birmingham, AL 35209
Tel. (205) 871-6600 Fax (205) 871-6680

FINANCIAL POLICY

It is our commitment to provide to all our patients the highest quality dental care available, in a caring and friendly atmosphere. To have those services comfortably affordable, we are pleased to offer you these options for payment.

PERSONAL CREDIT CARDS	PREPAYMENT
VISA Discover MasterCard American Express	We are delighted to accept your personal check or cash for all treatment.

We are pleased to offer a monthly payment option through Care Credit.
Please ask our administrative staff for details and credit applications

We will support you in understanding your dental health and you may trust that our experience and guidance will enable you to make the best choices.	As a courtesy, we will be happy to process your insurance benefits in our office. We will do our best to estimate any out of pocket expense. All co-pays and deductibles are due at the day services are provided.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. I agree to pay any estimated portion of treatment not covered by dental benefits at the time of service.

Delinquent accounts: Should my account become delinquent and require the services of a collection agency or an attorney, I will pay all collection fees, court cost and attorney's fees for said collection. I also waive rights of exemption under the constitution and laws of Alabama or any other state as to personal property.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. Please help us to serve you by keeping your scheduled appointments. If you fail to keep your appointment, or come in late, the Doctor may request that you reschedule the appointment and you may be charged a fee. If for any reason you should need to change your appointment, there will be no charge, provided you give us 24-hour notice. Please make your questions and concerns known to our team. We are here to assist you in any way possible. Our goal is to ensure that you have an outstanding experience.

Signature (Responsible Party) Financial Coordinator Date

Homewood Dental Associates

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOU AND YOUR CHILD/CHILDREN'S HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your and your child's/children's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your and your child's/children's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), 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 your or your child's/children's treatment for payment and healthcare operations. For example:

Treatment: We may use or disclose your child's/children's health information to a physician or other healthcare provider providing treatment to your child or children.

Payment: We may use and disclose your or your child's/children's information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your or your child's/children's 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 or your child's/children's health information for treatment, payment or healthcare operations, you may give us written authorization to use your or your child's/children's 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 or your child's/children's health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your or your child's/children's health information to you, as described in the Patient Rights section of this Notice. We may disclose your or your child's/children's health information to a family member, friend or other person to the extent necessary to help with your or your child's/children's healthcare or with payment for your or your child's/children's 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 notification of (including identifying or locating) a family member, your personal representative or another person responsible for your child's/children's care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your child's/children's health information, we will provide you with the 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 or your child's/children's 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 or your child's/children's health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your child's/children's health information to appropriate authorities if we reasonably believe they are possible victims of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's/children's health information to the extent necessary to avert a serious threat to your child's/children's 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 or your child's/children's 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 or your child's/children's 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also 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 fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will 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 a full explanation of our fee structure.)

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 or your child's/children's 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 child's/children's health information by alternative means or to alternative locations. (Requests **must be made 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 or your child's/children's 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 or your child's/children's privacy rights, or you disagree with a decision we made about access to your or your child's/children's health information or in response to a request you made to amend or restrict the use or disclosure of your or your child's/children's 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 or your child's/children's 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 Person: Dustin Turnipseed, D.M.D.

Telephone: (205) 871-6600 Fax: (205) 871-6680

Address: 2045 Medical Center Drive, Birmingham, AL. 35209

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Homewood Dental Associates

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 Child's/Children's Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We 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)

_____

_____

_____

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, Homewood Dental Associates and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/We have read this disclosure and agree that Homewood Dental Associates, its employees and/or agents may contact me/us as described above.

_____ _____

Responsible Party Signature Date