Periodontal Specialist of Memphis
Dr. Denise Mustiful-Martin D.D.S..L.L.C
1286 Peabody Avenue
Memphis, TN 38104
901-276-6000

Patient Information

Today's Date_____

First Name_____ Middle_____ Last Name_____

Date of Birth_____ Social Security Number_____ Sex: □ Male Female□

Address _____

City_____ State _____ Zip_____ Email Address_____

Cell Phone Number_____ Home Phone Number_____

□ Single □ Married □ Divorced □ Widowed □ Separated □ Long Term Partner □ Minor

Employer_____ Occupation_____

Employer Phone Number_____ Employer Address_____

Who should we thank for referring you? _____

Who is your general dentist? _____ Phone Number _____

In case of an emergency who should we contact? (Please provide two emergency contacts below.)

Emergency Contact Name_____ Relationship_____

Emergency Contact Phone Number(s) _____ _____

Emergency Contact Name_____ Relationship_____

Emergency Contact Phone Number(s) _____ _____

Primary Dental Insurance

Responsible Party First Name_____ Last Name_____ Date of Birth_____

Social Security Number_____ ID Number_____ Group Number_____

Insurance Company_____ Insurance Company Phone Number_____

Insurance Mailing Address_____

Policy Holder Employer _____ Relationship to Patient_____

Do you have a **Secondary** Dental Insurance? □Yes □No. Please list secondary insurance (below).

If **Applicable** please provide secondary insurance information the **same order** as Primary Insurance.

_____

_____

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Medical History

Aids (HIV): □Yes □No

Allergies: □ Yes No

Anemia: □ Yes □No

Anxiety: □ Yes □No

Arthritis: □Yes □ No

Asthma: □ Yes □ No

Bladder Disease: □ Yes □No

Burning in Mouth: □ Yes □ No

Cancer: □Yes □No

Chest Pains: □Yes □No

Chronic Cough: □ Yes □No

Congenital Heart Defect: □ Yes □No

Diabetes : □Yes □ No

Difficulty Breathing: □ Yes □ No

Drug Addiction: □Yes □No

Dry Mouth: □Yes □No

Epilepsy: □ Yes □No

Excessive Thirst: □Yes □No

Glaucoma: □Yes □No

Heart Disease: □Yes □No

Heart Murmur: □Yes □No

Hepatitis: □Yes □No

High Blood Pressure: □Yes □No

Insomnia: □Yes □No

Irregular Heartbeat: □Yes □No

Joint Replacement (Artificial Surgery): □Yes □ No

Kidney Disease: □Yes □No

Low Blood Pressure: □Yes □No

Metro Valve Prolapse: □Yes □No

Nose Bleeds: □Yes □No

Pacemaker: □Yes □No

Pain in Ear: □Yes □No

Prosthetic Artificial Heart Valve: □Yes □No

Rheumatic Fever: □Yes □No

Scarlet Fever: □Yes □No

Seizures □Yes □No

Severe Headaches(Migraines): □Yes □No

Sickle Cell Disease: □Yes □No

Stomach Ulcers: □Yes □No

Stroke: □Yes □No

Swollen Joints: □Yes □No

Thyroid Disease: □Yes □No

Venereal Disease: □Yes □No

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1. Have you had a heart attack?_____ If so when? _____

2. Have you had a heart surgery? _____ If so when? _____

3. Have you had any major surgeries? _____ When?_____

4. Are you under any stress? _____

5. Do you smoke? _____ If so how often?_____

6. Do you faint easily? _____

7. Do you bruise easily? _____

8. Are you overweight? _____

9. Are you underweight? _____

10. Are you taking Diet pills? _____

11. Do you get depressed easily? _____

12. Do you get Jittery? _____

13. Do you get numbness in hands or feet? _____

14. Do you have spells of exhaustion? _____

15. Are you in poor health? _____

16. Are you under Psychiatric Care or treatment? _____

16. Do you have Systemic Disease (Measles, Chicken Pox, Mumps, etc) _____

Are you under **Physicians** care? _____Physician Name _____ Reason_____

Please list **ALL** medications that you take. _____

_____

Are you allergic to: Penicillin, Sulfa, Erythromycin, Novacaine (Local Anesthetic),Codiene, Aspirin, Mycins, Tetracycline Demerol, Sedatives Adrenalin (Epinephrine), Other _____

FEMALE PATIENTS ONLY

Are you pregnant ? _____ If so how far along?_____ If not are you trying?_____

Are you nursing? _____ Have you had a Miscarriage or Stillborn? _____ Have you been through menopause_____

Are you taking Birth Control? _____ Do you experience Irregular Menstrual Periods? _____

Do you have ANY disease, conditions, or problem not listed? _____

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Dental History

Why are you seeing us today?_____
Do you see your Dentist Regularly?_____
Does seeing the Dentist make you nervous?_____
Do you feel nervous about having dental treatment?_____
Have you had a bad experience in a dental office?_____
When was your last teeth cleaning?_____ How often?_____
How often do you floss?_____
Have you had previous gum trouble or treatment?_____
How often do you brush your teeth?_____ Do you Rinse?_____
Type of Tooth Brush: Hard_____ Medium_____ Soft_____ Electric_____ Water-pik_____
Additional oral hygiene aids used?_____

Oral Habits and Symptoms

Do you press your tongue against teeth? _____
Do you feel your bite is off? _____
Do you Grind or Clinch your teeth together? _____
Do you wake up with sore jaws? _____
Do you feel teeth are loose and sensitive? _____
Do you chew on pen tops, pencils or eyeglasses between teeth? _____
Do you bite your nails?_____ Do you bite your lip or cheeks?_____
Do you have popping, clicking or soreness in jaw? _____
Do you have Dry mouth? _____ Do you have blisters, cold sores or mouth ulcers? _____
Do you have shifting or loose teeth? _____
Do you have sore, swollen, bleeding or tender gums? _____
Do you have receding gums? _____ Do you have bad breath? _____
Do you chew or dip tobacco products? _____

To my knowledge I have given an accurate report of my physical and medical health history. I have also reported any prior allergic or unusual reactions to drugs, food, Insects bites, anesthetics, pollens, dust, blood or body diseases, gums or skin reactions, abnormal bleeding or any other conditions related to my health.

I agree to any xrays, photograph's, filming, and recordings of the procedure to be performed.

In order for us to process your Dental Insurance Claim, Please sign this authorization form to submit claim to your Insurance Company. In doing so what the insurance company doesn't pay the patient is Responsible.

Please Sign(Print)_____ Signature_____Date_____

Parent/Guardian Sign(Print) _____ Signature_____ Date_____

Reviewed By (Doctor's Signature)_____

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Release of Information

My Doctor may disclose all or any part of the record of the patient to any group or organization which is or may be liable for or responsible for payment of all or part of the physicians, charges, including, but not limited to, insurance companies, medical or hospital service companies, workers compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under the Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim.

Please Print_____ Signature_____ Date_____

If patient is unable to sign, please have Patient's Representative sign

Please Print_____ Date_____

Signature_____

Contacting You

Occasionally we might contact you for matters of a routine nature (such as changing an appointment time). Due to confidentiality, we would like your input as to where it is acceptable for us to contact you. If such contact is necessary, the receptionist will only leave his /her name and your doctor's name and telephone number if you are not available when we call. No mention of Periodontal Specialist of Memphis or the nature of the call will be given to the person who takes your message, unless we have your permission to do so.

Please complete the following, If applicable, to guide us in your wished regarding contacting you:

- If we need to contact you, may we contact you by telephone at home? Yes_____ No_____
- May we leave a voicemail on your Cell phone or Home answering machine? Yes_____ No_____
- If we need to reach you can we contact you at work? Can we leave you a voicemail at work? Yes___ No___
- If we need to contact you can we contact you on your cell phone? Yes_____ No_____
- May we respond to you by email? Yes_____ No_____

I understand that despite Periodontal Specialists of Memphis best efforts to protect electronic communications, that I our present age it is impossible for email communication to be completely confidential. I accept that when email is used to communicate with my doctor that it is possible for an unauthorized individual to illegally access these messages. Even though this risk is minimal, I acknowledge that no communication via email, between me and my doctor at Periodontal Specialist of Memphis will be considered totally confidential.

Patient Sign (Print)_____ Signature_____ Date_____

Parent/Guardian Sign (Print) _____ Parent/Guardian Signature_____ Date_____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome to Periodontal Specialist of Memphis

We are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- If you need to **Cancel or Reschedule** your appointment or not able to keep your appointment please give us a call **24 hours** before your appointment.
- We will bill your insurance for you. However, the patient is required to provide the most **correct and updated** information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Co-pays are **due** at the time of service.
- Coinsurance, deductions and non-covered items are due **30 days** from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

These charges may include:

- **Returned** checks- $30.00
- **Missed** surgery appointments- $100.00

- **With my signature below, I hereby authorize assignment of financial benefits directly to Periodontal Specialist of Memphis. I understand that I am financially responsible for charges not covered by the assignment. I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financially responsibility with or without the use of insurance coverage.**

Print Patient Name_____ Patient Signature_____ Date_____

Print Parent/Guardian Name (if a minor)_____ Parent/Guardian Signature_____ Date_____

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HIPPA RELEASE FORM

Please complete **all** sections of this HIPPA release form. If any sections are left blank, this form will be invalid and it not be possible for your health information to be shared as requested.

I, _____ give my permission for _____

to share the information listed document with the following person(s).

☐ Disclose my complete health record including, but not limited to, medical history, diagnoses, treatment and billing, records for all conditions. (Please fill out below the names and healthcare providers to release information.)

☐ Disclose my complete health record except for the following information

- Medical History
- Billing Information
- Treatment Information

☐ I DO NOT wish to disclose my health record.

Name _____ Relationship_____

Name _____ Relationship _____

Name _____ Relationship_____

☐ I would like to give the following healthcare providers permission of my complete health record.

Doctor's Name_____ Phone number_____

Doctor's Name _____ Phone number _____

☐ I DO NOT wish to disclose my health record.

I understand that failure to sign/ submit this authorization or the cancellation of this authorization **will not** prevent me from receiving any treatment. This information is not required to determine if I'm eligible to receive treatment or insurance benefits to pay for the services that I receive.

Print Name:_____ Signature:_____ Date_____

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Please Print_____

Date_____

Signature_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledge 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)

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

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 took effect April 4, 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 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 healthcare 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 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 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 authorize 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 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.

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. 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.

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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.

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.