Periodontal Associates
OF MEMPHIS
Periodontal, Laser and Dental Implant Therapy

PLEASE PRINT PATIENT MEDICAL HISTORY

Patient's Name: | Name of guardian is patient is under the age of 18

Address: | Today's Date: | Date of Last Visit: | Date of Med. History

City State Zip: | Birth Date: | Social Security No.: | Marital Status:

Home Phone: | Cell phone: | Work Phone #: | Email:

Name of person who will be paying (if different from patient: | Home Phone #: | Work Phone #:

Billing Mailing Address (if different from patient's address: | Relationship to Patient:

Physician Name: | Physician Name:

Pharmacy: | Pharmacy Phone:

Do you have Dental Insurance?

☐ **Yes** ☐ **No**

Name of Patient or Dentist who referred you to our office: _____

Sex: ☐

If female, please answer the following:

Y N
☐ ☐ Are you taking birth control pills?
☐ ☐ Are you pregnant? If yes, # of weeks___
☐ ☐ Are you nursing?

Please answer the following:

Y N
☐ ☐ Do you smoke or use tobacco?

Height: ☐

For Office Use Only

BP: ☐ Heart Rate: ☐

Weight: ☐

Y N	Conditions
☐☐	Alcohol Abuse
☐☐	Allergies
☐☐	Anemia
☐☐	Angina Pectoris
☐☐	Arthritis
☐☐	Artificial Bones or Joints
☐☐	Artificial Heart Valve
☐☐	Blood Transfusion
☐☐	Cancer—Chemotherapy
☐☐	Colitis
☐☐	Congenital Heart Defect
☐☐	Cosmetic Surgery
☐☐	Diabetes
☐☐	Difficulty Breathing
☐☐	Drug Abuse
☐☐	Emphysema
☐☐	Epilepsy
☐☐	Fainting Spells Fever
☐☐	Blisters Frequent
☐☐	Headaches
☐☐	Glaucoma
☐☐	HIV+ AIDS

Y N	Conditions
☐☐	Hay Fever
☐☐	Heart Attack
☐☐	Heart Surgery
☐☐	Hemophilia
☐☐	Hepatitis A
☐☐	Hepatitis B
☐☐	High Blood Pressure
☐☐	Kidney Problems
☐☐	Liver Disease
☐☐	Low Blood Pressure
☐☐	Mitral Valve Prolapse
☐☐	Pace Maker
☐☐	Pneumocystitis
☐☐	Psychiatric Problems
☐☐	Radiation Therapy
☐☐	Rheumatic Fever
☐☐	Seizures
☐☐	Shingles
☐☐	Sickle Cell Disease
☐☐	Sinus Problems
☐☐	Stroke
☐☐	Thyroid Problems

Y N	Conditions
☐☐	Tuberculosis
☐☐	Ulcers
☐☐	Venereal Disease
☐☐	Yellow Jaundice
☐☐	Abnormal Bleeding/Hemophila
☐☐	Asthma/Allergies/Hay Fever

Y N	Allergies
☐☐	Aspirin
☐☐	Codeine
☐☐	Dental Anesthetics
☐☐	Erythromycin
☐☐	Jewelry
☐☐	Latex
☐☐	Metals
☐☐	Penicillin
☐☐	Tetracycline
☐☐	Iodine

Other:_____

Please ✓ RX or Over the Counter

MEDICATIONS or Herbal	QTY.	RX	O.T.C	REASON:

Please describe any disease, condition, or problem that you think this office should know about that has not already been listed:

Staff Notes:

The information on my PATIENT MEDICAL HISTORY is correct and complete to the best of my knowledge. I authorize the release of any medical information by my physician as it pertains to my dental care.

I agree to any x-rays, photography, filming or recording of the procedure to be performed and I authorize release for teaching purposes/publications.

Signature of Patient or Legal Guardian

Date

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6268 Poplar Avenue· Memphis, TN 38119 · phone 901-761-3770 · toll free 800-824-1628
fax 901-761-3775 www.PerioMem.com Info@PerioMem.com

Roger D. Craddock, D.D.S.
Mitchel S. Godat, D.D.S., M.S.
Board Certified Periodontist

Partners Emeritus:
Preston D. Miller, Jr., D.D.S.
James R. Ross, D.D.S., M.S.

NEW PATIENT PROFILE

Patient Name: _____ **Date:** _____

Our goal is to make your experience in our office exactly how you want it to be. Please take a few moments and complete this profile so we can make you as comfortable as possible.

1. Please rate, in order of value, what is most important to you in your dental care: (The most important will be #1.)
   - _____Preventive care
   - _____Only what is necessary at the time: Cost is important
   - _____Comprehensive, quality care to fully restore my mouth
   - _____Other _____

2. Please rate, as in #1, what is most important to you in your relationship with a dentist.
   - _____Show me what he/she is doing or planning to do so I can clearly see what is happening.
   - _____Listen to my concerns and explain what needs to be done so I can clearly hear and understand my needed treatment.
   - _____Make sure I feel comfortable and informed at all times.

3. Please check the level of fear you have regarding dental treatment.
   (10 being the most fearful, 1 being the least amount of fear.)
   1 2 3 4 5 6 7 8 9 10

4. I would like to know more about these options to maximize my comfort during my visits.
   - _____IV Sedation
   - _____Nitrous Oxide (laughing gas)
   - _____Sedative medication

5. Are you concerned about: (please check yes or no)
   - Yes No Replacing missing teeth.
   - Yes No Eliminating any disease present in your mouth.
   - Yes No Gum disease.
   - Yes No Bad breath.
   - Yes No The appearance of your smile.

6. Is keeping your natural teeth important to you? Yes No

7. I would like to keep my natural teeth until _____.

8. When we review your treatment plan with you would you like to know (please check one):
   - _____The big picture of what needs to be done or
   - _____All the treatment details along the way

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FINANCIAL POLICIES

Payment

Please read carefully & initial each paragraph verifying the financial policies have been read and understood. Patient or financial responsible party signature is required below indicating a commitment to pay for all account balances.

___Payment is due in full at the time of treatment unless prior arrangements have been approved. Patient or Financial Responsible Party is liable for any financial arrangements agreed upon.

___Patient or Financial Responsible Party will be responsible for finance charges of 1.5% per month which will accrue on account balances 90 days or more. If the account is turned over to a COLLECTION agency, other added fess will include a 35% collection fee (or more depending on collection agency charge), court costs, attorney fees or any other fees associated with the collection process.

Dental Insurance

If you have dental insurance, please initial these paragraphs, sign below & complete DENTAL INSURANCE INFORMATON on the back of this page.

___It is the responsibility of the patient or policy holder of the Dental Insurance to contact the Dental Insurance company to determine in or out of network costs for any procedure. For questions about Dental Insurance, the patient or policyholder should always contact the Dental Insurance Company first.

___Dental Insurance companies do not give Periodontal Associates of Memphis a guarantee of payment; therefore, we can only give you an estimate of what insurance may pay. The patient or policyholder is responsible for all balances not paid by the Dental Insurance Company. The Dental Insurance Company may quote Usual & Customary fees, however, these fees are not the same as nor do they determine our fees.

___Periodontal Associates of Memphis will file claims to Primary Dental Insurance only. The patient or policyholder will be responsible for filing claims to any secondary dental insurance.

Medical Insurance

___Periodontal Associates of Memphis will only file claims to Dental Insurance. A financial arrangement will be based on Dental Insurance only. If Health or Medical insurance covers any procedures, it is the responsibility of the patient or policyholder to file the claim.

_____

Signature of Patient or Financially Responsible Party Date

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Dental Insurance Info/Update

If updating, mail to our address: Periodontal Associates of Memphis~ 6268 Poplar Ave. Memphis, TN 38119 or Fax to (901) 761-3775

Patient Name: _____ **Date**_____

PRIMARY DENTAL INSURANCE

Insurance Company:_____

Address_____ **Telephone #**_____

Group #_____ **ID #**_____

Policy Holder Name _____

Address (if different than patient's)_____

Date of Birth_____ **Social Security #**_____

Employer_____ **Address**_____
(If retired, list employer & employer address providing your dental insurance)

Pt.'s relationship to Policyholder: (Self)_____ (Spouse)_____ (Child)_____ (Other) _____

Signature_____

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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 takes effect 9/23/13, 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.

Individuals 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.

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 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 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. 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), has 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.

Our Privacy Official: Barbara Patton

Telephone: 901-761-3770 Fax: 901-761-3775

Address: 6268 Poplar Avenue, Memphis, TN 38119

E-mail: officemanager@PerioMem.com

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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.

_____
Name (please print)

_____
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
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____

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Patient Name: _____Date of Birth_____

I agree that Periodontal Associates of Memphis (P.A.M.) may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing P.A.M. any updates to my email address.

I can withdraw my consent to electronic communications by calling 901-761-3770.

Email Address: (PRINT CLEARLY) _____

Patient's Signature: _____Date_____

How may we contact you regarding your treatment and/or appointments?

May our automated appointment reminder calling system
contact you at your home telephone number? Y or N

Home Phone:_____
May we leave a message on your answering machine? Y or N

May we leave a message with some one at your home? Y or N
With Whom? Anyone/Other_____Relationship?_____

Work Phone:_____
May we leave a message on your voice mail at work or with an individual? Y or N
With Whom? Anyone/Other_____Relationship?_____

Cell Phone:_____

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Institute For Advanced Laser Dentistry
SEMPER STUDIOSUM

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Patient Name _____ **Date of Birth** _____

I hereby give consent to Periodontal Associates of Memphis to disclose protected health information (PHI) to the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ I understand that I have the right to revoke this consent, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this consent.

Patient or Guardian Signature _____ **Date** _____

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PARENTAL AUTHORIZATION TO TREAT A MINOR

This form grants authority to a designated adult to attend appointments in place of myself as the legal custodian of _____.
I, _____ (Parent/Legal Guardian) also grant authority to this individual to provide and arrange for medical care for this minor in the event of an emergency.

Minor
Full Legal Name: _____ Date of Birth: _____
Home Address: _____

Designated Adult
Full Legal Name: _____ Date of Birth: _____
Home Address: _____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for _____ (hereafter "Designated Adult") to attend appointments in my place. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: _____.

Signed this _____day of_____, 20___.
Parent / Legal Guardian Signature: _____ Printed Name: _____
Witness Signature: _____ Printed Name: _____