NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health 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 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.

Effective April 14, 2003 (due to federal guidelines under HIPAA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

NAME	RELATIONSHIP	PHONE NUMBER

May we leave medical information on your "home" answering machine or cell phone? Yes__ No__

Signature of Patient/Parent_____ Date_____

OR

If you do not want any medical or financial information discussed with anyone other than yourself please sign here.

Signature of Patient/Parent_____ Date_____

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

Brittney W. Gilbert, D.M.D., LLC

Payment Policy and Consent for Treatment (Updated 8-17-17)

Accepted forms of Payment: Cash, Check, Visa, MasterCard, Discover, AmEx, Care Credit

1. Due to the High cost of billing, payment is due as services are rendered.
2. Patients with dental insurance:
    a. We will file your insurance for you and accept assignment directly from your insurance company, but your deductible and estimated co-payment for individual procedures will be due on the date of service (just as you pay your co-pay at your physician's office for specific services). Please remember that the relationship concerning your insurance is between you, the patient, and your insurance company. Filing your insurance is NOT a guarantee of payment, and any amounts not paid by your insurance company, for any reason, are your responsibility.
3. Account balances that are 60 days past due are subject to being assigned to a collection agency. The patient hereby agrees to waive any and all rights to claim personal property exempt from levy under the law of the State of Alabama. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees and/or court costs, if such be necessary.
4. The parent bringing a child to our office for treatment is responsible for payment of all charges for dental services rendered to that child.
5. A fee of $25 will be charged for "no shows". We ask that if you are not coming to your appointment, you call and give us 24 hours' notice, so that we may offer this time to other patients on our waiting list. We do understand that emergencies occasionally arise, and we will take that into consideration, but as a general rule, we will enforce the 24 hour cancellation notice. If you continue to miss appointments without notifying us, you are subject to losing appointment privileges. Also, if you are more than 15 minutes late for your appointment, we reserve the right to reschedule that appointment. We try very hard to stay on schedule and respect everyone's valuable time.
6. Payment plans are available by signing a permission form for monthly drafts from your debit or credit card. This is offered on an individual basis and can be arranged by our business staff. We do not extend credit in any other form.

Telephone Consumer Protection Act (TCPA)

You agree, in order for us to service your account or to collect monies you may owe, that Brittney W. Gilbert, D.M.D., LLC 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 device, as applicable.

I have read this disclosure agree and that Brittney W. Gilbert, D.M.D., LLC, its employees and/or agents may contact me as described above.

Responsible Party Signature: _____ Date: _____

I have read the above information, as well as our policy concerning insurance (if applicable) and agree to abide by the policies. I am aware that I, not my insurance company, am responsible for payment of my account.

Date: _____ Signed: _____ Relation: _____ (if responsible party)

I consent to the performance of operations, anesthetics, and procedures considered necessary or advisable by Brittney W. Gilbert, D.M.D., LLC.

Date: _____ Signed: _____ Relation: _____ (if responsible party)

Patient Name: _____ (Printed)

EAGLESOFT MEDICAL HISTORY

Patient Name: _____ 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.

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 every taken Fosamax, Moniva, Actonel, or any other medications containing bisphosphorates?	Yes ☐ No ☐	If yes _____
Are you on a special diet?	Yes ☐ No ☐	
Do you use tobacco?	Yes ☐ No ☐	
Do you use controlled substances?	Yes ☐ No ☐	If yes _____

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? _____

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

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

Have you ever had any serious illness not listed above? 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: Date:

PATIENT'S DENTAL HISTORY

Patient's Name: _____ Date of Birth: _____

Reason for this visit: _____

When was your last dental visit? What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (name and location)? _____

Have you had a complete series of dental films (x-rays) taken? If so, when/where? _____

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

Is your drinking water fluoridated? _____

Do your gums bleed while brushing or flossing?	Yes	No	Do you bite your lips or cheeks frequently?	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	Yes	No	Have you noticed any loosening of your teeth?	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No	Does food tend to become caught between your teeth?	Yes	No
Do you feel pain to any of your teeth?	Yes	No	Have you have had periodontal (gums) treatment?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No	Have you ever worn a bite plate or other appliance?	Yes	No
Have you had any head, neck, or jaw injuries?	Yes	No	Have you ever had any difficult extractions in the past?	Yes	No
Have you ever experienced any of the following problems in your jaw: Clicking Pain (joint, ear, side, or face) Difficulty in opening or closing? Difficult in chewing?	Yes	No	Have you ever had any prolonged bleeding following extractions?	Yes	No
			Do you wear dentures or partials? If yes, date of placement:	Yes	No
			Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes	No
Do you have frequent headaches?	Yes	No			
Do you clench or grind your teeth?	Yes	No			

If you could change <u>anything</u> about your smile, what would you change?

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third parter payors and/or health practitioners. I authorize and request my insurance company to pay directly tot he dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor: Date:

Doctor's comments:

Doctor's signature Date: