Patient Information Form

THOMAS J. MAZZUCHELLI, D.M.D.
AMERICAN DENTAL ASSOCIATION

Patient Information

Today's Date _____

Name _____

I prefer to be called: _____

M F

Birthdate _____ Age _____

SSN# _____

Address _____

City/State/Zip _____

Home Phone _____ Cell _____

Work Phone _____

Email address _____

Best Times to Reach You _____

Where _____ When _____

Employer Information

Employer _____

Employer's Address _____

City/State/Zip _____

Previous / Present Dentist _____

Other Family Members Seen by Us

_____

Whom may we thank for referring you?

_____

Spouse/Emergency Contact

Spouse _____

Spouse's Employer _____

Spouse's Work Phone _____

SSN# _____ DL# _____

In Case of Emergency, Please Contact

Name _____ Relation _____

Home Phone _____ Other _____

Work Phone _____

Partners in your dental health.

Primary Dental Insurance

Insurance Company _____

Address _____

City/State/Zip _____

Phone Number _____

Group # _____

Policy # _____

Insured's Name _____

Relation to Insured _____

Insured's Birthday _____

Insured's SSN# _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Company _____

Address _____

City/State/Zip _____

Phone Number _____

Group # _____

Policy # _____

Insured's Name _____

Relation to Insured _____

Insured's Birthday _____

Insured's SSN# _____

Insured's Employer _____

Person Responsible for Account

Name _____

Home Phone _____ Other _____

Work Phone _____

Billing Address _____

SSN# _____ DL# _____

Payment is due in full at time of treatment unless prior arrangements have been made with our office.

Medical History

Do you have a personal physician? Y N

Physician's Name _____

Phone _____ Date of Last Visit _____

Your health is Good Fair Poor

Have you been under the care of a physician in the last two years? Y N

Physician's Name _____

Please Explain _____

Have you been treated in a hospital in the last two years? Y N

Please explain _____

Your dental health is Good Fair Poor

Have you had any canker sores or cold sores on you lips, tongue, gums or body? Y N

Are you taking any medications or over the counter drugs? Y N

Please list each one:

_____

_____

_____

_____

Have you ever had any of the following diseases or medical problems?

High Blood Pressure	Y	N	Cancer/Chemotherapy	Y	N
Low Blood Pressure	Y	N	Radiation Treatments	Y	N
Heart Attack/Stroke	Y	N	Psychiatric Problems	Y	N
Any Heart Problems	Y	N	Epilepsy/Seizures/Fainting	Y	N
Heart Surgery	Y	N	Diabetes	Y	N
Pacemaker	Y	N	Tuberculosis	Y	N
Artificial Valves	Y	N	Venereal Disease	Y	N
Congenital Heart Defect	Y	N	Hemophilia	Y	N
Heart Murmur	Y	N	Abnormal Bleeding	Y	N
Rheumatic Fever	Y	N	Ulcers/Colitis	Y	N
Mitral Valve Prolapse	Y	N	Anemia	Y	N
Artificial Bones/Joints	Y	N	Asthma	Y	N
Kidney Problems	Y	N	Difficulty Breathing	Y	N
Shingles	Y	N	Arthritis	Y	N
HIV/AIDS	Y	N	Hepatitis	Y	N
Blood Transfusions	Y	N	Hospitalized for any reason	Y	N
Fever Blisters	Y	N	Emphysema	Y	N
Sinus Problems	Y	N	Glaucoma	Y	N
Severe/Frequent Headaches	Y	N	Thyroid Disease	Y	N

Are you currently taking or have you ever taken any bisphosphonate drugs or drugs for bone density? Y N

These include:

- *Alendronate (Fosomax)*
- *Clodronate (Ostac, Bonefos)*
- *Etidronate (Didronel)*
- *Ibandronate (Boniva)*
- *Reclast (Prolia)*
- *Pamidronate (Aredia)*
- *Risedronate (Actonel)*
- *Tiludronate (Skelid)*
- *Zoledronic Acid (Zometa)*

Please list any serious medical conditions; impending operations; or other medical or dental information that may possibly affect your dental treatment:

_____

_____

Are you allergic to any of the following drugs?

Penicillin	*Y*	*N*	*Dental Anesthetics*	*Y*	*N*
Aspririn	*Y*	*N*	*Codeine*	*Y*	*N*
Erythromycin	*Y*	*N*	*Latex*	*Y*	*N*
Tetracycline	*Y*	*N*	*Others, please list below*		

Other drug allergies:

_____

_____

For Women Only

Are you taking birth control pills? Y N

Are you pregnant? Y N Week#

Are you nursing? Y N

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence. It is my responsibility to inform the office of changes in my medical status. I authorize the dental staff of Drs. Johnson and Mazzuchelli to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____

Signature *Date*

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ *Date* _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ *Date* _____

I verbally reviewed the medical/dental information above with the patient named herein.

Initials _____ *Date* _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish the Cobb Dental Expressions to be able to discuss my medical condition.

I understand this form will be updated every calendar year. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Cobb Dental Expressions in writing of my decision.

In accordance with the above, I _____,
hereby authorize Cobb Dental Expressions to discuss with and release my medical information to the following individuals

_____ _____

_____ _____

NOTIFY IN CASE OF EMERGENCY _____

_____

The below individuals are authorized to pick up any written prescriptions, medication samples or x-ray films on my behalf.

_____ _____

_____ _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

_____ _____

_____ _____

Patient Signature_____

Date:_____

Witness:_____

COBB DENTAL EXPRESSIONS

Thomas J. Mazzuchelli D.M.D.
Roy H. Johnson D.D.S.

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), revised in 2014, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *NOTICE OF PRIVACY PRACTICES* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change *its NOTICE OF PRIVACY PRACTICES* from time to time and that I may contact this organization at any time to obtain a current copy of the *NOTICE OF PRIVACY PRACTICES*.

I understand/agree that general messages, such as appointment and medicaton reminders, may be left on my voicemail or email. I also understand/agree that occasionally detailed messages related to finances, dental treatment and pre-estimates are necessary and may be left on my voicemail or email, as well.

Patient Name or Legal Guardian _____

Signature _____

Date _____

For Practice Use Only

I attemtpted to obtain the patient's signature in acknowledgement of the NOTICE OF PRIVACY PRACTICES Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Notice of Privacy Practices
Cobb Dental Expressions

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you 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 are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency

where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Privacy Officer: Renae Holfels

Phone number: 770-973-5620

Fax number: 770-973-1515

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became

effective on 10/22/2014.

COBB DENTAL EXPRESSIONS

Thomas J. Mazzuchelli D.M.D.
Roy H. Johnson D.D.S.

INSURANCE FINANCIAL INFORMATION

****** PLEASE INDICATE WITH YOUR INITIALS THAT YOU HVE READ AND UNDERSTAND EACH STATEMENT******

AS A COURTESY, Cobb Dental Expressions will file your insurance. Our office staff will attempt to verify coverage, eligibility and an estimate of your benefits prior to treatment. Telephone estimates are not legally binding and often misunderstood or misinterpreted by the insured or insurer. **All phone verifications are a quote; NOT a guarantee of coverage or benefits.**

- ____ It is important for you to know what your insurance policy covers. We recommend that **YOU** check with your insurance company if you have any questions regarding your benefits. Most insurance companies only verify general benefit information to doctors' offices.
- ____ To get a better idea of what will be covered by your insurance company; we suggest a pre-estimate that can take up to 6-8 weeks to process. Even this is still not a guarantee of benefit coverage.
- ____ **In-network or plan participation** does not guarantee coverage for a specific procedure; it simply identifies those providers willing to share with your overall healthcare costs.
- ____ If you do not provide enough insurance information on the day of consultation, and it is not given prior to your treatment, our office policy is to collect in full the total amount of the treatment. If you are able to get us insurance information prior to the day of treatment, then benefits can be verified and estimated fees figured.
- ____ **ALL INSURANCE CLAIMS FILED CAN TAKE UP TO 30-90 DAYS TO PROCESS.** If you receive a bill from us before 30 days after you consult or treatment this is just a statement. Anything after 30 days may be owed, ***please contact your insurance to check the status of the claim.*** YOUR insurance will send you an "Explanation of Benefits" approximately TWO weeks before they send it to us.
- ____ All reimbursement decisions by your carrier are made strictly in accordance with plan provisions and patient eligibility at the time the service is actually preformed. You will need to deal directly with your carrier after 120 days for reimbursement.
- ____ All financial obligations must be paid in full the day of treatment. Should you need assistance with you payment, we suggest Care Credit at 1-866-893-7864 or www.carecredit.com.

Patient Signature:_____ Date: _____

Patient Name Printed:_____

COBB DENTAL EXPRESSIONS

Thomas J. Mazzuchelli D.M.D.
Roy H. Johnson D.D.S.

FINANCIAL AGREEMENT
(No insurance)

****** PLEASE INDICATE WITH YOUR INITIALS THAT YOU HVE READ AND UNDERSTAND EACH STATEMENT******

- ____Patients without dental insurance benefits are expected to pay the balance **IN FULL when services are rendered.**
- ____ Payment arrangements can be discussed (**IN RARE CASES)** on services over $500. This requires an installment agreement set up through the front desk manager.
- ____ All financial obligations must be paid in full the day of treatment. Should you need assistance with your payment, we suggest Care Credit at 1-866-893-7864 or www.carecredit.com.
- ____ We reserve the right to take legal action on any delinquent account, including turning the account over for collection, reporting the delinquency to the credit bureau and if necessary, filing suit.

Patient Signature:_____ Date: _____

Patient Name Printed:_____

Patient Evaluation Form

1. How did you hear about our practice?
   ____ Referred by a friend
   ____ Directory of dentists provided by my insurance company
   ____ I saw one of your advertisements
   ____ Walk by or drove by the practice
   ____ Internet

2. Date of your last hygiene visit: _____

3. On a scale of 1 to 5 (1 being bad, 5 being good)
   Please rate how you feel your overall dental health is.
   1 2 4 5

4. On a scale of 1 to 5 (1 being not faithful, 5 being faithful)
   Over the last ten years rate how faithfully you
   have had your teeth cleaned?
   1 2 3 4 5

5. On a Scale of 1 to 5 (1 being not sensitive, 5 being very sensitive)
   What is your level of sensitivity to dental procedures?
   1 2 3 4 5

5. On a Scale of 1 to 5 (1 being not sensitive, 5 being very sensitive)
   What is your sensitivity to cleaning visits?
   1 2 3 4 5

6. Rate how you feel about your smile and the
   appearance of your teeth.
   (1 being unhappy, 5 being very happy)
   1 2 3 4 5

8. Are you interested in regular hygiene cleanings?
   ____Yes ____No

9. What is the main reason for your Visit Today?

   _____ Tooth Pain
   _____ I need a check-up
   _____ Cleaning
   _____ Whitening
   _____ Cosmetic Dentistry
   _____ Other_____

10. I would like to learn more about?

   _____ Whitening
   _____ Cosmetic Dentistry
   _____Implants
   _____ Bridges
   _____ Veneers
   _____ Dentures
   _____ Other_____

11. How do you rate your quality of sleep?
   (1 being poor, 5 being great)
   1 2 3 4 5

12. If you snore how would you rate the severity of your snoring? (1 being none and 5 being severe)

   1 2 3 4 5