Welcome to our Practice

Confidential Health History

Patient Information

Date _____
Patient Name _____
Address _____
E-mail _____
City _____
State _____ Zip _____
Sex _ M _ F Birth date _____
Social Security # _____

_ Married _ Widowed _ Single
_ Minor _ Separated _ Divorced
_ Partnered for ____ yrs

Patient Employer/School_____
Occupation _____
Employer/School Address _____
_____
Spouse's Name _____
Spouse's Birth date _____
Spouse's Social Security # _____
Spouse's Employer _____

Who may we thank for referring you?

_____

Dental Insurance

Who is responsible for this account? _____
Relationship to patient _____
Insurance Company _____
Group # _____ ID # _____

Is the patient covered by an additional dental insurance? _ Yes _ No
Subscriber's Name _____
Relationship to Patient _____
Insurance Company _____
Group # _____ ID # _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Lawhorn, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to patient _____

Dental History

Reason for today's visit _____
Former Dentist _____
City/State _____
Date of last dental visit _____
Date of last dental x-rays _____

Please check all that apply:

_ Bad Breath
_ Bleeding Gums
_ Blisters on lips or mouth
_ Burning sensation on tongue
_ Chew on one side of mouth
_ Cigarette, pipe or cigar smoking
_ Clicking or popping jaw
_ Dry mouth
_ Fingernail biting
_ Food collection between the teeth
_ Foreign objects
_ Grinding teeth
_ Gums swollen or tender
_ Jaw pain or tiredness
_ Lip or cheek biting
_ Loose teeth or broken fillings
_ Mouth breathing
_ Mouth pain, brushing
_ Orthodontic treatment
_ Pain around ear
_ Periodontal Treatment
_ Sensitivity to cold
_ Sensitivity to heat
_ Sensitivity to sweets
_ Sensitivity when biting
_ Sores or growths in your mouth

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

Health History

Physician's Name,_____ City, State _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) _ Yes _ No

Please check all that apply:
_ Aids/HIV
_ Anemia
_ Arthritis, Rheumatism
_ Artificial Heart Valves
_ Artificial Joints
_ Asthma
_ Back Problems
_ Bleeding abnormally, with extractions or surgery
_ Blood Disease
_ Cancer
_ Chemical Dependency
_ Chemotherapy
_ Circulatory Problems
_ Congenital Heart Lesions
_ Cortisone Treatments
_ Cough, persistent or bloody
_ Diabetes
_ Emphysema
_ Epilepsy
_ Fainting or dizziness
_ Glaucoma
_ Headaches
_ Heart Murmur
_ Heart Problems
_ Hepatitis Type ____
_ Herpes
_ High Blood Pressure
_ Jaundice
_ Jaw Pain
_ Kidney Disease
_ Liver Disease
_ Low Blood Pressure
_ Mitral Valve Prolapse
_ Nervous Problems
_ Pacemaker
_ Psychiatric Care
_ Radiation Treatment
_ Respiratory Disease
_ Rheumatic Fever
_ Scarlet Fever
_ Shortness of Breath
_ Sinus Trouble
_ Skin Rash
_ Special Diet
_ Stroke
_ Swollen Feet or Ankles
_ Swollen Neck Glands
_ Thyroid Problems
_ Tonsilitis
_ Tuberculosis
_ Tumor or Growth on head or neck
_ Ulcer
_ Venereal Disease
_ Weight loss, unexplained

Do you wear contact lenses? _ Yes _ No
Women:
Are you pregnant? _ Yes _ No If yes, Due Date _____
Are you nursing? _ Yes _ No Taking Birth Control Pills? _ Yes _ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____

Pharmacy name _____
Pharmacy phone number _____

Allergies

_ Aspirin
_ Barbiturates (Sleeping Pills)
_ Codeine
_ Iodine
_ Latex
_ Local Anesthetic
_ Penicillin
_ Sulfa
_ Other _____

Phone Numbers

Home Phone _____ Work Phone _____
Cell Phone _____ Spouses Work _____
Best time and place to reach you: _____

In Case of Emergency, contact (Specify someone who does not live in your household)

Name _____ Relationship _____
Home Phone _____ Work Phone _____

AUTHORITY TO RELEASE DENTAL RECORDS

To The Office of (Doctor) _____

(Address) _____

(City, State, Zip) _____

From (Patient) _____

(Address) _____

(City, State, Zip) _____

Please call us (or we'll call you) before sending any x-rays or records so we do not get material we do not need and/or will not use. Thank you.

You are hereby authorized to furnish and release to my dentist, Timothy M. Lawhorn, DDS, all information and records, concerning findings, x-rays and treatment needed. The foregoing authority shall continue until revoked by me in writing.

Signature of patient, parent or guardian _____

Dated: _____

Phone: (406) 543-3777 Fax: (406) 543-6205
690 SW Higgins Suite E, Missoula, MT 59803

Digital records may be emailed to: kendal@fullcaredental.com

Full Care Dental PLLC

NOTICE OF PRIVACY PRACTICES

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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 takes effect today, 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 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 health 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 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 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. If you request copies, we will charge you $0.___ for each page, $___ per hour 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 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.

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.

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.

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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. 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.

Contact Officer: Kendal Grissom, Office Coordinator

Telephone: (406) 543-3777 Fax: (406) 543-6205

Address: 690 Southwest Higgins, Suite E, Missoula MT 59803

www.FullCareDental.com

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.

Full Care Dental PLLC

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 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)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Financial Agreement

This agreement is to inform you of your financial obligation to our practice and to help you better understand the complexities of dental insurance. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement.

As a courtesy to you we will process all your insurance claims.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments.

Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

We accept cash, checks, all major credit cards, and monthly payments through our financing partner CareCredit. Returned checks and balances older than 60 days will be subject to collection fees. Appointments that are missed or rescheduled without 48 hours' notice will be subject to a $75 missed appointment fee.

We hope this information has been helpful. Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____

Print Name of Patient

_____ _____

Signature of Patient or Responsible Party Date