Location: ☐ McCalla ☐ Cahaba ☐ Southlake

Luma
DENTISTRY

Patient Information

Confidential

Welcome!

Date _____

Name _____
First Middle Last Preferred

Address _____ Driver's license # _____

City _____ State _____ Zip _____

Soc. Sec.# _____ Birth Date _____ Age _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have any children or a spouse that are patients here? ☐ Yes ☐ No

Do you want to be on a separate account from your children and/or spouse? ☐ Yes ☐ No

Contact Information

Home (___)_____ Work (___)_____

Mobile (___)_____ Fax (___)_____

E-mail _____

In the event of an emergency, who should we contact?

Name _____

Relationship _____

Work Phone (___)_____

Home Phone (___)_____

How did you hear about us?

☐ Sign or Store Front

☐ Yellow Book

☐ Family

☐ Friend _____

☐ Website

☐ Mailing _____

☐ Other _____

Employer or School _____ Occupation _____

City _____ State _____ Zip _____

[Please turn over to complete form]

Responsible Party

Who is responsible for this account? _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Home Phone (___)_____ Work Phone (___)_____

Soc. Sec.# _____ Are they a patient here? ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship _____

Employer _____ DOB _____ Soc. Sec.# _____

Ins. Company _____ Ins. ID _____ Group # _____

Do you have any secondary insurance? ☐ Yes ☐ No If yes, complete the following.

Name of insured _____ Relationship _____

Employer _____ DOB _____ Soc. Sec.# _____

Ins. Company _____ Ins. ID _____ Group # _____

Media Release

I authorize the use of my photos or cases for educational and marketing purposes for Luma Dentistry.

_____ _____

Signature Date

Financial Information

Payment for services is expected at the time service is provided. Cash, checks, and credit card payments are welcome. Extended payment programs are available.

My preferred method of payment is:

☐ **PREPAYMENT RESULTING IN DISCOUNT**
☐ **CASH/CHECK/CREDIT CARD TO RESERVE or**
☐ **INTEREST FREE FINANCING*** *(*subject to credit approval)*

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable collections and attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (~18% annual rate) unless prior arrangements have been made. If the account is in default and turned over for collection, a collection fee will be added.

Broken appointments or cancellations without a 48-hour notice are subject to a fee.

If you have dental insurance, your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.

We currently accept most insurance plans. Although we maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **only an estimate**.

Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are managed care facilities, which have reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary."

We file your insurance as a courtesy. If insurance does not pay within 90 days, Luma Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. **Ultimately, you are responsible for all charges incurred in our office.**

I hereby authorize payment directly to Luma Dentistry of the group insurance benefits otherwise payable to me.

_____ _____ _____

Print **Patient** Name | Signature of responsible party | Date

Patient Dental History

PATIENT NAME: _____ Date _____

Are you having any pain? ☐ Yes ☐ No

Do you have any sensitivity to hot, cold, or sweets? ☐ Yes ☐ No

Does dental treatment make you nervous? ☐ Yes ☐ No

If yes to any of the above, please explain. _____

Which of the following concern you about dental treatment?

☐ Time "I am very busy."
☐ Fear "I am afraid of one or more things about dental treatment."
☐ Cost "I may need or want to make payments."
☐ Other _____

Have you experienced any of the following problems?

☐ Bleeding gums
☐ Soreness in the jaw
☐ Snoring
☐ Trouble chewing
☐ Bad breath
☐ Grinding of teeth
☐ Frequent headaches
☐ Loose teeth

On a scale of 1-5 with 5 being the highest:

How important is your dental health to you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Where would you rate your dental health?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Where would you like your dental health to be?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

How would you rate your smile? ☐ Embarrassing ☐ Decent ☐ Okay ☐ Perfect

When was the last time you had your teeth cleaned? _____

When was the last time you had an Oral Cancer Screening? _____

Is the whiteness of your teeth important to you?	☐ No	☐ Yes
Do you use tobacco in any form? How much?	☐ No	☐ Yes _____
Do you routinely drink coffee, tea, or red wine?	☐ No	☐ Yes

If I could change my smile, I would:

☐ Make my teeth whiter
☐ Have less gum showing
☐ Repair chipped teeth
☐ Replace missing teeth
☐ Close spaces
☐ Make my teeth straighter
☐ Change silver fillings into tooth colored
☐ Replace any old crowns or caps that don't match

What is your daily routine of cleaning your teeth? How much time do you spend each day doing that?

_____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

Medical Health History

PATIENT NAME: _____ Date _____

Physician _____ Office Phone _____ Date of Last Exam _____

	YES	NO
Do you use tobacco?	☐	☐
How much? _____		
Do you use alcohol?	☐	☐
How much? _____		
Have you used any illicit drugs?	☐	☐
What substance? _____		
How recently? _____		
Do you wear contact lenses?	☐	☐

	YES	NO
Are you under medical treatment now?	☐	☐
Explain _____		
Have you had any surgeries or hospitalization in the past 5 years?	☐	☐
Explain _____		
For women only		
Are you or might you be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

Allergies

	YES	NO		YES	NO
Barbiturates	☐	☐	Penicillin	☐	☐
Aspirin	☐	☐	Other Antibiotics	☐	☐
Sedatives	☐	☐	Local Anesthetics	☐	☐
Iodine	☐	☐	Sulfa Drugs	☐	☐
Latex	☐	☐	Other _____	☐	☐

Medications

List any medications you are currently taking including over-the-counter medications and herbals:

_____ _____

_____ _____

_____ _____

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

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐			

COMMENTS _____

_____

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.

Signature _____

PATIENT, PARENT OR GUARDIAN DATE

Luma
DENTISTRY

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 April 14, 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 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 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.

[Please turn over]

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, e-mail, text messaging, 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. 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.

Restrictions: 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.

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: Kellie Hobson
Telephone: 205.477.4242
Fax: 205.477.4243
Address: 5751 Pocahontas Road, Suite A, McCalla, AL 35022

Luma
DENTISTRY

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify) _____

_____

_____

_____

Please list individuals that we can release your medical information to:

_____