

Patient Name:

Birth Date:

Date Created:

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

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 ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No If yes

Do you use tobacco? 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 Allergies? Yes No If yes

If yes to any allergies, what is/was your reaction? If yes

Do you use controlled substances? Yes No If yes

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

- AIDS/HIV Positive Yes No
- Alzheimer's Disease Yes No
- Anaphylaxis Yes No
- Anemia Yes No
- Angina Yes No
- Arthritis/Gout Yes No
- Artificial Heart Valve Yes No
- Artificial Joint Yes No
- Asthma Yes No
- Blood Disease Yes No
- Blood Transfusion Yes No
- Breathing Problems Yes No
- Bruise Easily Yes No
- Cancer Yes No
- Chemotherapy Yes No
- Chest Pains Yes No
- Cold Sores/Fever Blisters Yes No
- Congenital Heart Disorder Yes No
- Convulsions Yes No
- Yellow Jaundice Yes No

- Cortisone Medicine Yes No
- Diabetes Yes No
- Drug Addiction Yes No
- Easily Winded Yes No
- Emphysema Yes No
- Epilepsy or Seizures Yes No
- Excessive Bleeding Yes No
- Excessive Thirst Yes No
- Fainting Spells/Dizziness Yes No
- Frequent Cough Yes No
- Frequent Diarrhea Yes No
- Frequent Headaches Yes No
- Genital Herpes Yes No
- Glaucoma Yes No
- Hay Fever Yes No
- Heart Attack/Failure Yes No
- Heart Murmur Yes No
- Heart Pacemaker Yes No
- Heart Trouble/Disease Yes No

- Hemophilia Yes No
- Hepatitis A Yes No
- Hepatitis B or C Yes No
- Herpes Yes No
- High Blood Pressure Yes No
- High Cholesterol Yes No
- Hives or Rash Yes No
- Hypoglycemia Yes No
- Irregular Heartbeat Yes No
- Kidney Problems Yes No
- Leukemia Yes No
- Liver Disease Yes No
- Low Blood Pressure Yes No
- Lung Disease Yes No
- Mitral Valve Prolapse Yes No
- Osteoporosis Yes No
- Pain in Jaw Joints Yes No
- Parathyroid Disease Yes No
- Psychiatric Care Yes No

- Radiation Treatments Yes No
- Recent Weight Loss Yes No
- Renal Dialysis Yes No
- Rheumatic Fever Yes No
- Rheumatism Yes No
- Scarlet Fever Yes No
- Shingles Yes No
- Sickle Cell Disease Yes No
- Sinus Trouble Yes No
- Spina Bifida Yes No
- Stomach/Intestinal Disease Yes No
- Stroke Yes No
- Swelling of Limbs Yes No
- Thyroid Disease Yes No
- Tonsillitis Yes No
- Tuberculosis Yes No
- Tumors or Growths Yes No
- Ulcers Yes No
- Venereal Disease Yes No

Have you ever had any serious illness not listed 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:

X

Date: _____

APPOINTMENTS, CANCELLATIONS, AND INSURANCE POLICY

SARINA HARMAN-TINNEL, D.D.S.

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least **24 hours notice**. This courtesy makes it possible to give your reserved room to another patient.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit.

There is a \$50.00 charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

If there has been any changes to your dental insurance it is your responsibility to notify the office with the information prior to your appointment or at the time of check in at your scheduled appointment. We strive to keep our records accurate and up to date, if insurance has lapsed and our office was not notified, the balance then becomes the patient's responsibility and is due within 60 days of treatment.

I, _____ on this date _____ have been informed of the cancellation policy and fully understand that **a less than 24 hours notice** will result in a late cancellation fee of **\$50.00**.

I, _____ on this date _____ have been informed that I need to advise the office of any recent updates or changes regarding dental insurance prior to receiving treatment or I may incur the full balance of charges.

Responsibility for Payment

It is your responsibility to give your dental insurance information to our office at the first appointment or at the first indication that your insurance has changed.

While insurance is meant to be an aid, it in no way dictates the treatment we may recommend for you. Our treatment plans are based upon our professional diagnosis and are not meant to follow or be dictated by your benefits. Insurance is not considered a guarantee of payment and payment may be denied for certain procedures even though the patient and the dentist agree that the submitted treatment plan is in the patient's best interest.

If the proposed treatment is provided, the patient must understand that the payment is his/her sole responsibility. Also, if any collection action is necessary the undersigned will be responsible for reasonable collection cost as well.

Patient Name

Signature

Date

**Sarina Harman-Tinnel, D.D.S.
11644 West 75th Street, Suite 101
Shawnee, Kansas 66214**

Authorization for Communication

I hereby authorize the office staff of Sarina Harman-Tinnel, D.D.S. to leave a phone message regarding the following information for:

Dental Appointments at:

Work

Cell

Home

Account Information at:

Work

Cell

Home

Medical Information at:

Work

Cell

Home

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)

Sarina Harman-Tinnel

Notice of Privacy Practices

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

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Sarina Harman-Tinnel's ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us

If you have any questions or would like further information about this Notice, you can contact Dr. Sarina Harman-Tinnel at:

Address: 11644 W. 75th St. Suite 101

City, St, Zip: Shawnee, KS 66214.

Phone: (913)-631-0064

E-mail: sarina@drtinnel.com

III. Our promise to you and our legal obligations

The Privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;

- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on 10/01/2013

Effective date of notice: 10/01/2013

NOTICE OF PRIVACY PRACTICES

Dr. Sarina Harman-Tinnel, D.D.S.

11644 W. 75th Street, Suite 101
Shawnee, KS 66214

913-962-0036

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

We will ask for special written permission in the following situations: Records release.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

uses or disclosures for health related research;

uses and disclosures to prevent a serious threat to health or safety;

uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

disclosures of de-identified information;

disclosures relating to worker's compensation programs;

disclosures of a "limited data set" for research, public health, or health care operations;

incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

other uses and disclosures affected by state law.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are

- reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.