



Welcome to the dental practice of Thunder Bay Family Dentistry!

Thank you for choosing Thunder Bay Family Dentistry for your family dental care. We want this opportunity to welcome you to our practice and to offer you assistance in making your visit comfortable.

Enclosed you will find the following:

- Patient Registration Form
- Medical History Form
- Notice of Privacy Practices
- Acknowledgement of Receipt of Notice of Privacy Practices
- Consent Form for purposes of Treatment, Payment & Healthcare Operations (HIPPA)
- Financial Policy and Dental Insurance Information Letter
- Records Transfer Form (if needed)

In order to shorten your registration time when you arrive for your appointment, please complete the enclosed Patient Registration and Medical History Forms. Please also review and sign the HIPPA Consent and Financial Policy. We would like to have these completed forms and a copy of your most recent dental insurance card at least a day prior to your appointment, but you may bring them with you the day of your appointment if it is not convenient to do so otherwise.

Our practice participates with Delta Dental. We will accept and bill a number of other major dental insurances as a courtesy. We ask that you be somewhat familiar with your particular insurance policy. If you have any specific questions about your policy, please contact Kari at 989-354-8112 or your insurance carrier. We have enclosed a Dental Insurance Information Letter to help you better understand some of the basic insurance principles.

If you need to change or cancel your appointment, please contact us within 24 hours of your scheduled time. This is a courtesy to our patients who may be on a waiting list to see the doctor.

We will attempt to call you one to two days before your appointment to confirm the date and time. If you have any questions before your appointment, please call us at 989-354-8112.



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

				Chart #.	<input type="text"/>	
				FOR OFFICE USE ONLY		
Patient Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
	Last	First	MI	Preferred Name		
Title:	<input type="text"/>	Gender:	<input type="radio"/> Male <input type="radio"/> Female	Family Status:	<input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Child <input type="radio"/> Other	
	Mr/Ms/Mrs/etc					
Birth Date:	<input type="text"/>	SS #.	<input type="text"/>	Prev. Visit:	<input type="text"/>	
Email Address:	<input type="text"/>			Best time to call:	<input type="text"/>	
Phone:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Home	Work	Ext	Mobile	Fax	Other
Address:	<input type="text"/>		<input type="text"/>			
	<input type="text"/>		<input type="text"/>	<input type="text"/>		
	City		State	Zip Code		
Preferred appointment times:						
<input type="checkbox"/> Mon	<input type="checkbox"/> Tue	<input type="checkbox"/> Wed	<input type="checkbox"/> Thur	<input type="checkbox"/> Fri	<input type="checkbox"/> Sat	
<input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening	<input type="checkbox"/> Any time			
Whom may we thank for referring you to our practice?						
<input type="checkbox"/> Dental Office	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Internet				
<input type="checkbox"/> Newspaper	<input type="checkbox"/> School	<input type="checkbox"/> Work				
<input type="checkbox"/> Other (name below):						
Name of person, office, or other source referring you to our practice:						
<input type="text"/>						

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name:
Last First MI Preferred Name

Title: Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc

Birth Date: Email Address:

Phone: Best time to call:
Home Work Ext Mobile

Address:

City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: Phone:

Address:

City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured:

LastFirstMI

Insured's Birth Date: ID #: Group #:

Insured's Address:

CityStateZip Code

Insured's Employer Name:

Employer Address:

CityStateZip Code

Patient's relationship to insured:

Self Spouse Child Other

Insurance Plan Name:

Insurance Address:

CityStateZip Code

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured:
Last First MI

Insured's Birth Date: ID #: Group #:

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date:

Relationship to Patient:

Response Date:

PARENTAL CONSENT FOR MINORS

Father: _____

Mother: _____

Grandparent: _____

Legal Guardianship

☐ Father

☐ Mother

☐ Father and Mother

☐ Grandparent

I/We, _____ give my/our permission as the legal guardian(s) of:

To be examined and/or treated in my/our absence by the dental professionals of Thunder Bay Family Dentistry.

I/We give my/our permission for the following individuals below to bring in, be present, and give consent for treatment in the event I/we can not be present myself/ourselves.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I can recant this document at any time I feel it is necessary.

Signature: _____

Signature: _____



Medical History

Patient Name:
Last First MI Preferred Name

Birth 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, please explain:

Have you ever been hospitalized or had a major operation?

* ☐ Yes ☐ No

If yes, please explain:

Are you taking any medications, pills, or drugs?

* ☐ Yes ☐ No

Medications List:

*

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

* ☐ Yes ☐ No

Bisphosphonate taken and duration:

Do you use tobacco?

* ☐ Yes ☐ No

Women: Are you

Pregnant/Trying to get pregnant?

☐ Yes ☐ No

Taking oral contraceptives?

☐ Yes ☐ No

Nursing?

☐ Yes ☐ No

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

- | | | | |
|-----------------------------------------------------------------|---------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergy - Aspirin |
| <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other |
| <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Seasonal | <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Alzheimers/Dementia |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores/Blisters | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Frequent Headache | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Attack/Failure
Murmur/Prolaps | <input type="checkbox"/> Heart Disease | | |

- | | | | |
|----------------------------------------------|---------------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hives/Rash | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Jaw Pain/Discomfort | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> See Health History | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors/Growths | <input type="checkbox"/> Ulcers | |

Have you ever had any serious illness not listed above?

* ☐ Yes ☐ No

If yes, please explain:

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: _____

Date:

Response Date:



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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2010, 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 provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, 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.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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 the protected health information of an 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).

PATIENTS 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. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we reserve the right to charge you a nominal fee of \$35.00 to 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

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: **Jack H Behl DDS**

Telephone: **(989) 354-8112** Fax: **(989) 354-3542**

E-mail: admin@thunderbayfamdent.com

Address: **2229 US 23 South Alpena, MI 49707**



PAYMENT AND FINANCIAL POLICY

We would like to thank you for choosing Thunder Bay Family Dentistry to provide you your dental care. We are committed to providing you with quality and affordable dental care. Because you may have some questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it and feel free to ask any questions that you may have. A copy will be provided to you upon request.

FOR OUR INSURED PATIENTS:

Copays: All copays must be paid at the time of service.

Deductibles: Some insurance policies have deductible requirements. These are your responsibility and will be billed to you. Payment is due within 29 days of receipt of your statement.

Non-covered services: Some, and perhaps all, of the services that you receive may be non-covered, or not considered necessary by your insurance. These services are your responsibility and will be billed to you. Payment is due within 29 days of receipt of your statement.

Submitting claims: We will submit your claims and assist in every reasonable way we can to get your claims paid. However, there may be times when your insurance requires information from you directly. It is your responsibility to provide this information if or when it is requested. If your claim is denied because you failed to provide this information, the balance will become your responsibility.

Proof of Insurance: All patients must complete our registration forms. We must also obtain a copy of your current insurance card. If you do not have this available at your appointment, and do not produce it within a reasonable amount of time, you will be responsible for your services.

Change in coverage: If your insurance changes, please notify us prior to your appointment.

FOR OUR SELF-PAY PATIENTS:

Payment is due at the time of service. If you need an estimate for your services, please ask to speak to Kari.

FOR ALL PATIENTS:

Payment Financing: We have partnered with CareCredit Health Care Financial Services to provide you affordable, interest free, monthly payment options. Information and an application for Care Credit can be found at www.carecredit.com or by contacting our office ahead of your scheduled appointment.

No-Show appointments: There is a minimal \$50.00 fee for appointments not cancelled 24 hours prior to an appointment. We understand that certain circumstances arise and will extend a courtesy for a couple of legitimate excuses. The fee is normally charged this out on the third documented no communication, no-show appointment. This fee is not payable by insurance and must be paid prior to your next appointment. Upon a third no communication no-show appointment, we reserve the right to discharge you from the practice and ask you to find services at another practice where your schedule is better matched.

Copy Fees: If you need your records copied, there is a nominal fee of \$35.00. Payment for these copies is due before the copies leave the office.

Collection procedures: If your account is over 90 days old, you will receive a letter stating that you have 10 days to pay your account in full. Please be aware that if your balance remains unpaid, we will submit the balance to an outside collection agency. Any future treatment following any collection procedure must be paid in full prior to time of service. An alternative action taken may be that you and your immediate family members may be subject to discharge from our practice.

Thank you for understanding our payment and financial policy. If you have any questions regarding this document, please let us know.

I have read this Payment and Financial Policy document and fully understand its contents:

Signature

Date

DENTAL INSURANCE INFORMATION LETTER

Dear Patients:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception – dental insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payment.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. 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.

However, it should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask for Kari or April, and should be able to give clarification on services, billing, and insurance coverage.

Thank you



Dear Dr. _____:

I, _____, request the release of my dental records to the practice of Thunder Bay Family Dentistry.

Please release the information requested by Thunder Bay Family Dentistry, so that they can continue on with my dental care.

Thank you for your time in processing this information in a timely manner.

Please also include the following immediate family members for dental record release as well:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Signature: _____

Date: _____