DR. DALLAS PULLIAM
DR. KEN FETTER
DR. GRETA RICHTER

PATIENT INFORMATION

Please Print

Patient Information

PATIENT'S NAME

STREET ADDRESS

CITY, STATE, ZIP

MAILING ADDRESS

E-MAIL ADDRESS

PRIMARY PHONE H W C

SECONDARY PHONE EXT H W C

DATE OF BIRTH SEX M F

MARITAL STATUS MARRIED DIVORCED SINGLE WIDOWED

PATIENT'S SOCIAL SECURITY NUMBER

PARENT/ RESPONSIBLE PERSON

PARENT'S SOCIAL SECURITY NUMBER

WHO IS FINANCIALLY RESPONSIBLE FOR THE DENTAL BILL?

HOW DID YOU HEAR ABOUT OUR PRACTICE? (Please check one)

- ○ DR'S PREVIOUS PATIENT
- ○ INSURANCE COMPANY WEBSITE
- ○ FRIEND OR FAMILY (Name?)
  _____
- ○ WEBSITE
- ○ DRIVING/ WALKING BY OFFICE
- ○ OUTSIDE REFERRAL FROM DOCTOR (Name?)
  _____
- ○ GOOGLE SEARCH
- ○ MAILER
- ○ OTHER _____

Dental Insurance (if applicable)

PRIMARY INSURANCE COMPANY PHONE NUMBER

ADDRESS (STREET, CITY, STATE, ZIP)

NAME OF INSURED RELATIONSHIP TO PATIENT

SSN OF INSURED INSURED'S DATE OF BIRTH

GROUP NAME / EMPLOYER

GROUP NUMBER I.D. NUMBER

SECONDARY INSURANCE COMPANY PHONE NUMBER

ADDRESS (STREET, CITY, STATE, ZIP)

NAME OF INSURED RELATIONSHIP TO PATIENT

SSN OF INSURED INSURED'S DATE OF BIRTH

GROUP NAME / EMPLOYER

GROUP NUMBER I.D. NUMBER

School & Employment

IS THIS PATIENT EMPLOYED? YES NO

NAME OF EMPLOYER

EMPLOYER'S ADDRESS

IS THE PATIENT A FULL-TIME STUDENT? YES NO

NAME OF SCHOOL

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature _____ Date _____

Dr. Dallas Pulliam
Dr. Ken Fetter
Dr. Greta Richter

MEDICAL HISTORY

Name _____ DOB _____

Are you in good health? ◯ Yes ◯ No Has there been any change in your general health within the past year? ◯ Yes ◯ No

My last physical examination was on _____ The name of my physician is: _____Phone _____

Are you now under the care of a physician? ◯ Yes ◯ No If so, what is the condition being treated? _____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? ◯ Yes ◯ No If so, for what? _____

Are you a smoker? ◯ Yes ◯ No Do you use controlled substances? ◯ Yes ◯ No Are you on a special diet? ◯ Yes ◯ No

Are you taking any medicine(s) including non-prescription medicine? ◯ Yes ◯ No If so, what medicine(s)? _____

_____

Women: Are you…

Pregnant/ trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic or have you had a reaction to:

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetic/ Epinephrine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Other _____

_____

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

AIDS/ HIV Positive	◯Yes ◯ No	Cortisone Medicine	◯Yes ◯ No	Hemophilia	◯Yes ◯ No	Recent Weight Loss	◯Yes ◯ No
Alzheimer's Disease	◯Yes ◯ No	Diabetes	◯Yes ◯ No	Hepatitis A	◯Yes ◯ No	Renal Dialysis	◯Yes ◯ No
Anaphylaxis	◯Yes ◯ No	Drug Addiction	◯Yes ◯ No	Hepatitis B or C	◯Yes ◯ No	Rheumatic Fever	◯Yes ◯ No
Anemia	◯Yes ◯ No	Easily Winded	◯Yes ◯ No	Herpes	◯Yes ◯ No	Rheumatism	◯Yes ◯ No
Angina	◯Yes ◯ No	Emphysema	◯Yes ◯ No	High Blood Pressure	◯Yes ◯ No	Scarlet Fever	◯Yes ◯ No
Arthritis/ Gout	◯Yes ◯ No	Epilepsy or Seizures	◯Yes ◯ No	High Cholesterol	◯Yes ◯ No	Shingles	◯Yes ◯ No
Artificial Heart Valve	◯Yes ◯ No	Excessive Bleeding	◯Yes ◯ No	Hives or Rash	◯Yes ◯ No	Sickle Cell Disease	◯Yes ◯ No
Artificial Joint	◯Yes ◯ No	Excessive Thirst	◯Yes ◯ No	Hypoglycemia	◯Yes ◯ No	Sinus Trouble	◯Yes ◯ No
Asthma	◯Yes ◯ No	Fainting /Dizziness	◯Yes ◯ No	Irregular Heartbeat	◯Yes ◯ No	Spina Bifida	◯Yes ◯ No
Bisphosphonate Use	◯Yes ◯ No	Frequent Cough	◯Yes ◯ No	Kidney Problems	◯Yes ◯ No	Stomach/Intestinal Dis.	◯Yes ◯ No
Blood Disease	◯Yes ◯No	Frequent Diarrhea	◯Yes ◯ No	Leukemia	◯Yes ◯ No	Stroke	◯Yes ◯ No
Blood Transfusion	◯Yes ◯No	Frequent Headaches	◯Yes ◯ No	Liver Disease	◯Yes ◯ No	Swelling Of Limbs	◯Yes ◯ No
Breathing Problem	◯Yes ◯No	Genital Herpes	◯Yes ◯ No	Low Blood Pressure	◯Yes ◯ No	Thyroid Disease	◯Yes ◯ No
Bruise Easily	◯Yes ◯ No	Glaucoma	◯Yes ◯ No	Lung Disease	◯Yes ◯ No	Tonsillitis	◯Yes ◯ No
Cancer	◯Yes ◯No	Hay Fever	◯Yes ◯ No	Mitral Valve Prolapse	◯Yes ◯ No	Tuberculosis	◯Yes ◯ No
Chemotherapy	◯Yes ◯No	Head/ Neck Injury	◯Yes ◯ No	Osteoporosis	◯Yes ◯ No	Tumors or Growths	◯Yes ◯ No
Chest Pains	◯Yes ◯ No	Heart Attack/ Failure	◯Yes ◯ No	Pain In Jaw Joints	◯Yes ◯ No	Ulcers	◯Yes ◯ No
Cold Sores/Fever Blister	◯Yes ◯ No	Heart Murmur	◯Yes ◯ No	Parathyroid Disease	◯Yes ◯ No	Venereal Disease	◯Yes ◯ No
Congenital Heart Dis.	◯Yes ◯ No	Heart Pacemaker	◯Yes ◯ No	Psychiatric Care	◯Yes ◯ No	Yellow Jaundice	◯Yes ◯ No
Convulsions	◯Yes ◯ No	Heart Trouble/ Disease	◯Yes ◯ No	Radiation Treatments	◯Yes ◯ No		

Have you ever had any serious illness not listed above? ◯Yes ◯ No _____

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 _____ Date _____

Dr. Dallas Pulliam
Dr. Ken Fetter
Dr. Greta Richter

FINANCIAL POLICY

Name _____ DOB _____

Welcome to our practice and thank you for choosing our office for your dental health care. We are committed to providing the highest quality dental care possible, and your satisfaction and comfort are our utmost priority. Our ability to consistently deliver that level of care is dependent upon smooth flow of payment. Please familiarize yourself with our financial policy as follows. This policy, as well as other health and insurance forms provided must be read, agreed to, and signed prior to the rendering of any dental treatment.

For your convenience, we accept cash, personal checks, and most major credit cards. We also offer financing via Care-Credit (subject to credit approval). For those without dental insurance, payment for services is expected in full on the day the service is initiated. If you have dental insurance with which we participate, we will have estimated the expected insurance payment for a given portion of your total treatment. We request that you pay your estimated portion in full at the first treatment appointment. Sometimes insurance companies cover less than the estimated amount. In this case, we will bill you for the additional amount due. If insurance pays more than we estimate, you will have a credit on your account, which can be refunded to you or left on the account to use toward future treatment.

Our insurance coordinators deal with many different insurance companies. Some companies offer many different dental and medical plans. These companies can change benefits, co-pays, and deductibles many times throughout the year. We do our best to provide you with accurate coverage estimates based on information available to us. At times, it is almost impossible to accurately estimate a patient's insurance co-payment. Dealing with these companies can be difficult and time consuming. As a courtesy, we ask that you keep us informed of any change to your insurance. It is important that all information about you and your insurance is current. We also encourage you to be familiar with your dental insurance coverage and exclusions, as ultimately the responsibility of payment and insurance dealings lies with you.

Sometimes an insurance company will determine that they will pay only a partial payment for treatment rendered after the fact. In order to protect against unexpected out-of-pocket cost, we would be happy to pre-authorize any major work that is recommended for you.

There will be a $50.00 charge for appointments cancelled or unattended with less than 24 hour notice. After 2 missed appointments each scheduled for more than 1 hour in duration, you will be asked to pre-pay your non-insurance costs in order to reserve future appointment time.

The above policies apply equally to parents and legal guardians of minors (less than 18 years of age) being treated and minors cannot be treated without a parent or guardian authorizing treatment and agreeing to financial responsibility in writing.

Thank you for reading and understanding our office financial policy. Should you have any questions or concerns, please feel free to ask them at any time. We wish to be of assistance in any way we can.

I understand and agree to the information above. I also understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered and that it is ultimately my responsibility to be aware of my insurance benefits.

Signature of Patient, Parent, or Guardian _____ Date _____

Dr. Dallas Pulliam
Dr. Ken Fetter
Dr. Greta Richter

NOTICE OF PRIVACY PRACTICES

Name _____ DOB _____

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. FOR QUESTIONS, CONTACT 610-688-4578.

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 usually will not ask you for special written permission.

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;

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.

YOURRIGHTS 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.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I received a copy of the Notice of Privacy Practices.

Signature _____ Date _____

Dr. Dallas Pulliam
Dr. Ken Fetter
Dr. Greta Richter

COMMUNICATION CONSENT

Name _____ DOB _____

HIPAA CONSENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgement in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

☐ You may communicate with the following individuals relating to my medical or payment information:

_____

_____

☐ Please *do not* communicate with the following individuals relating to my medical or payment information:

_____

_____

☐ Please *do not* communicate with *anyone* relating to my medical or payment information.

_____

_____

PREFERRED METHOD OF CONTACT

Can we leave a message on an answering machine/ voicemail/ text?

Home # _____ ◯ yes ◯ no Cell # _____ ◯ yes ◯ no

Work # _____ ◯ yes ◯ no Other # _____ ◯ yes ◯ no

Can we send a message via your email?

Information stored on our computers is encrypted. However, most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available on the U.S. Department of Health and Human Services website. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

☐ OPTION 1 – ALLOW UNENCRYPTED EMAIL I understand the risks of unencrypted email and do hereby give permission to the above dentists/ dental office to send me personal health information via unencrypted email.

Email address _____

☐ OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL I do not wish to receive personal health information via email

I authorize confidential communication about my healthcare to myself (and others, if applicable), as outlined above.

Signature of Patient_____ Date _____

Dr. Dallas Pulliam
Dr. Ken Fetter
Dr. Greta Richter

HIPAA AUTHORIZATION

Name _____ DOB _____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described in this form.

Signature_____ Date _____

Dr. Dallas Pulliam
Dr. Ken Fetter
Dr. Greta Richter

Assignment of Benefits Form

Name _____ DOB _____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all dental, medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other dental/health/medical plan, to issue payment check(s) directly to the dentists or dental office for dental or medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or the agreed amount for services rendered.

Authorization to Release Information

I hereby authorize the above dentists/ dental office to:

(1) Release any information necessary to insurance carriers regarding my illness and treatments;

(2) Process insurance claims generated in the course of examination or treatment; and

(3) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing. I have requested medical services from the above dentists/ dental office on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I hereby affirm that any payment made to me by my Insurance Carrier will be immediately transferred to the above dentists/ dental office upon receipt for services rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement EOB or Check.

A photocopy of this assignment is to be considered as valid as the original.

I understand and agree to the information above.

Signature of Patient, Parent, or Guardian _____ Date _____

Witness Signature _____ Date _____