BRUMBACH
family dentistry

PATIENT INFORMATION

Patient Name (Last, First, MI): _____ Preferred Name_____
Sex: M / F Birth Date: ___ /___ /____ Age:_____ Social Security #_____ Marital Status: S/M/D/W
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (___)_____ Cell Phone: (___)_____ E-Mail Address:_____
Best way to contact you: home/cell/work/email Referred by: _____
Other family member(s) seen in our office:_____
Employer: _____ Work Phone: (___)_____ May we call you at work? _____
Nearest Friend or Relative not residing with you: _____ Phone (___) _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relationship to Patient: _____
Birth Date: ____/____/____ ID #_____Employer:_____
Insurance Company: _____ Group #_____
Insurance Address: _____ City: _____ State: _____ Zip: _____

SECONDARY DENTAL INSURANCE (IF APPLICABLE)

Subscriber Name: _____ Relationship to Patient: _____
Birth Date: ____/____/____ ID #_____/____/_____Employer:_____
Insurance Company: _____ Group # _____
Insurance Address: _____ City: _____ State: _____ Zip: _____

ACCOUNT INFORMATION

Person responsible for account other than yourself: _____ Relation: _____
Home Phone: (___)_____ Social Security # _____ Birth Date: ____/____/___
Mailing Address: _____ City: _____ State: _____ Zip: _____

I certify that I am covered by _____ insurance company and I assign directly to Dr. Zach Brumbach all insurance benefits; otherwise payable to me. I understand that I am responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the dental staff to perform the necessary dental services I may need. I authorize the use of the signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature (Parent or Guardian) Date

609 North Calgary Court, Suite 104, Post Falls, ID 83854 | (208) 777-1222
scheduling@brumbachdentistry.com | www.brumbachdentistry.com

Welcome!

We are so glad that you have chosen us to care for your dental health. We will do everything possible to ensure that you have the most comfortable and superior dental care. We would like you to review and understand the following policies.

Payment Policy

To keep our fees to you as low as possible, we require your payment in full, or the portion that we estimate will not be covered by your insurance, at the time of your dental visit. We offer outside financing for your dental care through Care Credit. If you wish to utilize this service, please request an application form. This application must be submitted and approved prior to your dental care visit.

Insurance Policy

If you have dental insurance that will assist you with your dental care, we will be happy to file your dental claims. We ask that you familiarize yourself with your insurance benefits and provide us with any changes to your policy as soon as they occur. Please remember that your insurance is a contract between you, your employer and the insurance company. Not all services are covered benefits. You are ultimately responsible for the total amount of your dental fees and you may receive an additional billing after your insurance has paid.

Collection Policy

If an account remains unpaid after several attempts to collect have been made, $100 collection fee will be added to the balance and the account will be turned over to a collection agency. The outstanding debt will be reported to a national credit rating service. You will be responsible for any additional fees that are incurred.

Cancellation Policy

We value each patient's time and consider your appointment a commitment from our office to serve your needs in a timely and professional manner. Your appointment time is reserved exclusively for you. Absolutely no penalty will apply to changes in schedule made 48 hours in advance. Changes in schedule made with less than 48 hours notice are subject to a $25 fee for each half hour that is reserved. (1 hour=$50). We realize that emergencies do occur however, and we will be flexible under those circumstances.

For your convenience we have listed the methods of payment that we accept. Please note we give 5% bookkeeping courtesy for accounts paid in full prior to treatment by cash or check. Please identify the form of payment that is most convenient for you:

_____Cash/Check _____Credit Card (Visa, MasterCard) _____Care Credit

We are so happy to have you as our patient! If you have any questions regarding these policies, please don't hesitate to ask. Please sign below and return this copy to our receptionist for your file.

Signed:_____Date:_____

If you would like a copy of this document for your records, please request one from the receptionist.

HIPAA Notice of Privacy Practices

Dr. Zach Brumbach
609 Calgary Ct., Ste. 104
Post Falls, ID 83854
(208) 777-1222

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital of admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your requests. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice e has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)-Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information- This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction.

You have the right to request to receive confidential communications- You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information- If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive and accounting of certain disclosures- You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this for, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of out Notice of Privacy Practices.

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, or have been given the opportunity to receive, a copy of Dr. Brumbach's *Notice of Privacy Practices.* This notice describes the types of uses and disclosures of my personal health information that might occur in my treatment, payment for services, or in the performance of office health care operations. It also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

ADDITIONAL DISCLOSURE AUTHORITY

1. In additional to the allowable disclosures described in the Notice of Privacy practices, I hereby specifically authorize disclosure of my protected health care information to any member of my immediate family.
2. I understand that you may occasionally need to leave a message regarding an appointment or to request information. A message may be left with the person answering the phone or on my voicemail/answering machine.

Patient Name (Please Print) Date

Signature Relationship (if other than Patient)

DENTAL HISTORY FORM

PLEASE CIRCLE or FILL IN WITH THE APPROPRIATE INFORMATION ***Name:***

Yes No 1. Are you in dental discomfort today?

If so, explain: _____

2. How long has it been since your last teeth cleaning? _____

3. How long has it been since your last dental treatment? _____

4. What was done at that time? _____

5. When were x-rays last taken? _____

6. What do you need to be more comfortable or relaxed during dental visits?_____

Yes No 7. Have you ever had any serious trouble associated with any previous dental treatment?

If so, explain: _____

Yes No 8. Do you clench or grind your teeth?

Yes No 9. Have you ever had any unfavorable reaction from a dental anesthetic?

If so, explain: _____

Yes No 10. Are any of your teeth sensitive? (Check if applicable)…

- ☐ hot _____
- ☐ cold _____
- ☐ sweets _____
- ☐ pressure _____ _

Yes No 11. Do you use tobacco? If so, type and amount: _____

12. Have you seen a dental specialist or had any of the following treatment? (Check if applicable)

- ☐ Orthodontic (braces) _____
- ☐ Endodontic (root canal filling) _____
- ☐ Periodontal (gum disease) _____
- ☐ Oral Surgeon (extractions) _____
- ☐ Other _____

13. What would you change, if anything, about the appearance of your teeth and smile? (Check if applicable)

- ☐ Color _____
- ☐ Shape _____
- ☐ Crowding _____
- ☐ Missing Teeth _____
- ☐ Other _____

MEDICAL HEALTH FORM

Patient name: _____ Date: _____

Medical Physician's name: _____ Physician's Ph #_____

Yes No 1. Has there been any change in your general health in the last year? _____

Yes No 2. Have you been a patient in the hospital during the past five years? _____

Yes No 3. Have you been under the care of a physician during the past two years? _____

Yes No 4. Have you taken any medication or drugs during the past two years? _____

Yes No 5. Are you now taking any medication, drugs or pills including supplements and nonprescription drugs?

If yes, please list _____

_____

Yes No 6. Do you have or have you had a problem with alcohol or drugs?

Yes No 7. Have you ever taken Phenfen (Redux or Pondamin)?

Yes No 8. *Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?*

- ☐ Penicillin/antibiotics _____
- ☐ Drugs/medications _____
- ☐ Local anesthetics _____
- ☐ Latex/rubber _____
- ☐ Metals _____
- ☐ Other _____

Do you have or have you had any of the following? (Please circle if any of the following apply)

Heart ailment	Arteriosclerosis	Heart Murmur/Defect	Mitral Valve Prolapse
Rheumatic Fever	Chest Pain/Angina	Pacemaker	High or Low Blood Pressure
Artificial Joint or Valve	Steroids/Cortisone	Fainting/Dizziness	Stroke
Bruise easily	Abnormal bleeding	Blood transfusion	Anemia or Blood disorder
Kidney disease	Thyroid problems	Hepatitis/Liver disease	Diabetes (or family history)
Emphysema	Arthritis	Lumps/Swollen Glands	Allergies or Hives
Asthma	Sinus trouble	Chronic cough	Breathing/Lung problems
Venereal Disease	HIV positive or AIDS	Alcoholism	Drug addiction
Ulcers	Herpes or Cold sores	Cancer or Tumor	Radiation/Chemotherapy
Neurological condition	Epilepsy/Seizures	Glaucoma	Frequent headaches

Do you have any disease, condition, or problem that may interfere with dental treatment that is not listed above?

_____

FOR WOMEN:

1. Are you pregnant? ☐ Yes ☐ No Due Date _____
2. Are you nursing? ☐ Yes ☐ No
3. Are you taking birth control pills ☐ Yes ☐ No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient, Parent or Guardian _____ Date: _____