Tucker Dental Excellence II, P.C.

NEW PATIENT INFORMATION

Name: _____ Title: _____

Address: _____ City/State: _____ Zip: _____

Preferred Name: _____ SSN: _____ DOB_____

Home Phone: _____ Cellphone: _____

Email Address: _____ Marital Status: S M D W Sex: M F

How were you referred to our office? _____

How would you like to be reminded of appointments? Text _____ Email _____ Phone_____

Previous Dentist:_____

Date of last Cleaning: _____ Date of last X-rays: _____

Any dental concerns: _____

Are you happy with the appearance of your teeth? _____

Primary Dental Insurance Coverage

Subscriber Name: _____ Relation to patient: _____

Address: _____ City/State: _____ Zip: _____

SSN: _____ DOB: _____

Employer Name: _____ Employer Address: _____

Plan Name: _____ Group Number: _____

Insurance Company: _____ Member ID: _____

Insurance Company Address: _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ Relation to patient: _____

Address: _____ City/State: _____ Zip: _____

SSN: _____ DOB: _____

Employer Name: _____ Employer Address: _____

Plan Name: _____ Group Number: _____

Insurance Company: _____ Member ID: _____

Insurance Company Address: _____

Responsible Party

Name: _____

Address: _____

Signature: _____

Tucker Dental Excellence II, P.C.

Name: _____ Birthdate: _____

Parent or Guardian Name, if patient is a minor: _____

Health History (Please circle if you have any of the following)					
Yes	No	Chest pain, shortness of breath	Yes	No	Tumors, cancer
Yes	No	Bleeding problems or blood thinning medications	Yes	No	Psychiatric /Neurological care
Yes	No	Headaches	Yes	No	Kidney or bladder disease
Yes	No	Heart disease, heart murmur, rheumatic fever, prosthetic heart valve, mitral valve prolapse, or stent	Yes	No	Sexually transmitted disease
Yes	No	Pacemaker	Yes	No	HIV positive, AIDS
Yes	No	Heart Attack	Yes	No	Are you pregnant?
Yes	No	Hepatitis A, B, C or liver disease	Yes	No	Birth control pills
Yes	No	TB, asthma or lung disease	Yes	No	Stroke or TIA
Yes	No	Do you smoke?	Yes	No	Seizure disorders
Yes	No	High blood pressure, hypertension	Yes	No	Artificial joint
Yes	No	Adverse reaction to local anesthetic	Yes	No	Are you unable to wear a CPAP?
Yes	No	Do you use a CPAP?	Yes	No	Excessive daytime sleepiness
Yes	No	Have you ever had a sleep study?	Yes	No	Do you have a medical marijuana card?
Yes	No	Do you wear an oral appliance while sleeping?	Yes	No	Do you snore?
Yes	No	Do you use CBD products?	Yes	No	Gerd / Acid Reflux
Yes	No	Diabetes	Yes	No	AFib
Yes	No	Thyroid problems	Yes	No	Orthodontics (braces) year _____
			Yes	No	Wison teeth extracted year _____

Yes No Have you ever taken any of the following medications: Actonel, Fosamax, Boniva, or Zometa, or any other drug in the bisphosphonate class for osteopenia or "weak bones"?

Yes No Do you ever take medications such as Viagra, Cialis or Levitra for ED?

Are you allergic or do you suffer ill effects from any of the following:

Penicillin Aspirin Codeine Household Bleach Latex Sulfa Medications Peanuts Shellfish Dyes (for xrays)

List any allergies: _____

_____

List all mediations: _____

_____

Dentist Signature:	Date:
Patient Signature:	Date:

Tucker Dental Excellence
3736 Sterrettania Rd.
Erie, PA 16506
814-836-7777
frontdesk@tuckerdentalexcellence.com

APPOINTMENT POLICY AND AGREEMENT

Our goal is to provide quality dental care in a timely manner. In order to do so, we ask that patients adhere to our cancellation and no show policy.We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment with another patient who desperatley needs dental care. This policy enable us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patients' needs , please be courteous and call our office prompty if you are unable to attend an appointment. This allows us enough time to offer your appointment time to someone who is in urgent need of treatment. We ask that you contact our **office two business days (48 hours) in advance** to cancel or reschedule your appointment. You must speak with a member of our staff.

NO SHOW POLICY

A 'No show' is an appointment that was not canceled in advance (minimum of 24 hours in advance). No shows inconvience other patients who need dental care. A 'no show' for a scheduled appointment will result in a fee of $50. You will not be rescheduled until the fee has been paid. If you 'no show' to three (3) appointments in twelve (12) months you may be dismissed from care.

LATE ARRIVALS

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late , please call our office. If you are more than 10 minutes late to your appointment, you may be asked to reschedule.

NEW PATIENTS

Any missed appointment will not be rescheduled.

Any 'no show' that is documented may be discussed with the staff if you feel your 'no show' was unavoidable. If you have questions about the appointment policy and agreement , please speak with any member of our staff.
Thank you for choosing Tucker Dental Excellence for your dental needs. We look forward to a long lasting relationship with you.

ACKNOWLEDGEMENT

My signature below indicates that I have read, understand and agree to the appointment policy above.

_____ _____

Printed Patient Name Date

_____

Signature of Patient or Responsible Party

Tucker Dental Excellence II, P.C.

Insurance

Our Policy Regarding Dental Insurance

You are fortunate enough to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. WE accept payments from most insurance companies, which reduces your immediate out of pocket expense.

Regardless of what we may calculate your insurance company to pay out, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay for the entire cost of your treatment but is intended to help cover a certain portion of the cost. Better terms for dental insurance may be “dental assistance” or “dental benefits”.

Please remember, however, the financial obligation for dental treatment is between you and this office and is not between this office and your insurance company.

I have read and understand the above.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

Employee Signature: _____

Tucker Dental Excellence

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.

_____
Print Name

_____ _____
Signature Date

- Is there anyone you would like added for us to be able to speak to regarding your care

_____
_____
_____

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

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_____
_____

Tucker Dental Excellence II, P.C.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured 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 23, 2014, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practice, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law.
We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. 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, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may use or disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may use and 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.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose to PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example,

to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

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.

Our Privacy Official: Dr John H Tucker
Telephone: 814-836-7777 Fax: 814-836-7779
Address: 3736 Sterrettania Rd Erie, PA 16506

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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 website or by electronic mail (email).

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 if 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 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.