GLICK & WOODS
DENTISTRY

Welcome To Our Office

PATIENT INFORMATION (Please Print)

Name _____ Preferred Name _____

Address _____ SS# _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Sex: M ☐ F ☐ Date of Birth _____ Child ☐ Single ☐ Married ☐

Parent/Guardian Name _____ E-Mail Address _____

Patient/Parent Employed by _____

Can you be reached at work? Yes ☐ No ☐ How did you hear about our office? _____

Has anyone else in your immediate family ever been here before? Yes ☐ No ☐

Name _____ Name _____ Name _____

In case of emergency notify? _____ Home Phone _____ Work Phone _____

PRIMARY DENTAL INSURANCE _____

Person responsible for account _____

Relationship to Patient _____ Date of Birth _____ SSN# _____

Address if different from patient _____ Home Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Address _____

Employers Phone _____ Can you be reached at work? Yes ☐ No ☐

Insurance Company _____ Policy Holder _____

Group # _____ Subscriber # _____

ADDITIONAL DENTAL INSURANCE _____

Is patient covered by additional insurance? Yes ☐ No ☐

Policy Holder _____ Relationship to patient _____ Date of Birth _____

Employed by _____ Address _____

Employers Phone _____ Can you be reached at work? Yes ☐ No ☐

Insurance Company _____ Policy Holder _____

Group # _____ Subscriber # _____ SSN# _____

I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges regardless of insurance coverage. Payment is expected in full the day of service unless financial arrangements are made in advance of treatment. Patients are responsible for any attorney or collection fees. I agree to comply with the office policy and payment arrangements.

Signature _____ **Date** _____

Medical History

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

Hypoglycemia, Diabetes	YES/NO	Stroke	YES/NO
Heart Attack or Heart Trouble	YES/NO	Heart Murmur	YES/NO
Hay Fever, Allergies	YES/NO	Rheumatic Fever	YES/NO
High Blood Pressure	YES/NO	Anemia, Blood Disorder	YES/NO
Circulatory Problems	YES/NO	Excessive Bleeding	YES/NO
Hepatitis	YES/NO	Fainting/Blackouts	YES/NO
Jaundice	YES/NO	Nervous Disorders	YES/NO
Lung Problems, Tuberculosis	YES/NO	Headaches, Migraines	YES/NO
Epilepsy, Seizures	YES/NO	Kidney Problems	YES/NO
Blood Transfusions	YES/NO	Glaucoma, Eye Problems	YES/NO
Facial or Head Injuries	YES/NO	Ulcers, Digestive Problems	YES/NO
Radiation Treatments	YES/NO	Asthma	YES/NO
Malignancies, Cancer	YES/NO	Herpes (Mouth)	YES/NO
Chemotherapy	YES/NO	Latex Allergy	YES/NO
Sinus Problems	YES/NO	Other _____	
AIDS	YES/NO		

Name of Physician _____ Address _____ Phone _____

Name of Cardiologist _____ Address _____ Phone _____

Have you seen your physician or been hospitalized in the last (2) years? Yes No

If yes, please explain _____

Have you ever had an artificial joint replacement? Yes No **Do you have metal rods, pins, or screws placed in your body?** Yes No

Have you had a heart valve replacement? Yes No **Are you pregnant now?** Yes No

Are you now or have you ever been taking any blood thinning medication? Yes No

Are you being treated for osteoporosis (taking Actonel, Boniva, or Fosamax?) Yes No

Have you ever been pre-medicated (or recommended by your physician for previous dental appointments)? _____

Have you had unfavorable reactions to any of the following? (Please Circle)

Aspirin	Codeine	Anesthetics	Novocaine	Sedatives
Penicillin (Antibiotics)	Sulfa	Other Drugs		

Please list any drugs currently being taken: _____

_____

_____

The information above is correct to the best of my knowledge. I give my consent to have the necessary treatment recommended for my benefit (or my minor) only after it has been mutually approved.

Signature x_____ Date x_____

(Please turn over and fill-in dental history.)

DENTAL HISTORY

Date of last dental visit _____ Name of Dentist: _____

Address _____ Phone _____

Have you had any problems with previous dental treatment? Yes No Do you use tobacco? Yes No

Have you noticed any of the following: (Please Circle)

Teeth tender to chew on	Bleeding or sore gums	Recurring sore in or around mouth
Discomfort in face, head, neck	Sensitivity to sweets	Sensitivity to hot or cold
Food caught between teeth	Jaw clicking or popping	Swelling, lumps in mouth

Other: _____

To Be Completed By Staff

UPDATES

Date _____ Updated By: _____

Changes in General Health: Yes ☐ No ☐

Changes in Medication: Yes ☐ No ☐

Current Medications: _____

_____

_____

Signature _____

UPDATES

Date _____ Updated By: _____

Changes in General Health: Yes ☐ No ☐

Changes in Medication: Yes ☐ No ☐

Current Medications: _____

_____

_____

Signature _____

UPDATES

Date _____ Updated By: _____

Changes in General Health: Yes ☐ No ☐

Changes in Medication: Yes ☐ No ☐

Current Medications: _____

_____

_____

Signature _____

GLICK & WOODS DENTISTRY

208 North Washington Street
Tullahoma, Tennessee 37388

PATIENT RIGHT-TO-KNOW
CONSENT FOR DENTAL TREATMENT

State law requires us to obtain your consent for dental services. We are ready to answer any of your questions or explain anything you do not understand.

There are risks associated with any dental treatment. This includes exposure to radiation, the administration of any local anesthetic or prescription of anti-anxiety medications, antibiotics and/or pain medication. Some of these risks of complications are, but are not limited to the following:

Infection, injuries to adjacent teeth and/or hard or soft tissues, bleeding, failure of wound to heal, dry socket, loss of teeth, incomplete removal of tooth, loss of bone, injury to adjacent structures, instrument breakage, allergic reaction to drugs, bacterial endocarditis, breakage of root(s), death (in extremely rare instances), retained root fragments, swallowing and/or aspiration of objects, failure of treatment to accomplish its purpose, trismus (jaw pain or difficulty opening mouth), paresthesia or numbness of tongue and/or face, fracture of mandible (lower jaw) or maxilla (upper jaw).

Additional oral surgery, hospitalization and/or further treatment may be required in the event of a complication.

ACKNOWLEDGEMENT

I acknowledge that I have read this consent form, or that it has been read to me, and that I understand the information contained on this consent form. I was given an adequate opportunity to ask any questions and all questions that were asked were answered to my satisfaction.

I hereby authorize and direct the dentist and/or associates, hygienists, assistants of their choice to perform the diagnostic, surgical or dental treatment. This consent form will remain valid unless revoked by me in writing.

_____ _____

Signature of patient or guardian Date

_____ _____

Print name of patient or guardian (if applicable) Witness

GLICK & WOODS DENTISTRY
208 North Washington Street
Tullahoma, Tennessee 37388

Financial Policy

We consider our relationship with you to be of primary importance. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment.

Regarding Payment: Payment for services is due the day they are provided. We accept the following forms of payment: Cash, Check, Visa, Master Card, Discover & American Express. We also offer interest free financing options through CareCredit. We will assist you with the necessary application.

For patients who pay in full for dental care we offer up to a 20% refund of billing fees. Please ask when scheduling your appointment if any refunds apply.

Returned checks may be subject to additional fees.

Regarding Dental Insurance Patients: We will always do our best to help maximize your benefits. Although we file claims for you as a courtesy, your policy is a contract between you & your insurance company. If dental treatment is diagnosed for you, you will receive an itemized list of the recommended treatment, our fees & and a general estimate as to what your dental insurance may pay. We must emphasize that this is a general estimate and not a guarantee of payment or coverage. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. It is your responsibility to inform us before your appointment of any changes in your coverage. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within 90 days after the date of service, the full amount is due and payable by you.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. A finance charge may apply or if we have to refer your account out for collection, then collection fees, court costs or attorney fees may be due and payable by you.

Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate upon request.

Consent: I have read, understand and agree to the above terms & conditions. I authorize my insurance company to pay my dental benefits directly to this office.

WE REQUEST THAT ALL PATIENTS WITH DENTAL INSURANCE BRING THEIR ID CARD FOR US TO COPY

_____ _____

Responsible Party Date

GLICK & WOODS DENTISTRY
208 North Washington Street
Tullahoma, TN 37388
931-455-3917

Kim Glick, DDS Larry Woods, DDS

Caries Evaluation

Patient Name _____ Date _____

Please answer the 5 questions below. The objective of this questionnaire is to access your cavities risk.

1. Do you frequently use gum or mints containing sugar? _____Yes _____No

2. Do you frequently drink soda/fruit juice? _____Yes _____No
   How many per day? _____

3. Do you drink bottled or well water? _____Yes _____No

4. Do you brush less than 2 times per day? _____Yes _____No

5. Do you experience cold sensitivity? _____Yes _____No

If you answered yes to 2 or more of the above questions, you have a high risk of dental decay (cavities). Our goal is to be proactive and prevent cavities before they start. One way to help prevent cavities is to use home fluoride. Fluoride strengthens teeth to reduce the risk of decay. Your Dental Hygienist can tell you more about the benefits of fluoride.

Email Request Form

Glick & Woods Dentistry requests your email address in order to provide you with important dental care information on a timely basis.

We assure you that we will **NOT** share your email address with any 3rd party.

Please complete the information below and return it to one of our staff members.

Primary Email Address

Secondary Email Address

Patient's Name (please print)

Patient's Signature

Date

GLICK & WOODS DENTISTRY
208 North Washington Street
Tullahoma, Tennessee 37388
931-455-3917

Authorization to Access Dental Records

PATIENT
Name (print) _____ Date of Birth _____

I understand that my dental record may include a wide variety of information on diagnosis, treatment & procedures as well as personal information. Please list any family members or others who you give permission to view all the information found in your dental record.

Name (print):	Relationship to Patient:	Expiration Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

We will continue to rely on the information on this form unless you request changes. It is your responsibility to notify Glick & Woods Dentistry of any circumstance which may alter this authorization. To revoke or alter this authorization, please send a written request with a copy of this to Glick & Woods Dentistry, 208 N. Washington Street, Tullahoma, TN 37388.

Signature of Patient/
Legal Representative: _____ Date _____

Relationship to Patient: _____

GLICK & WOODS DENTISTRY

208 North Washington Street
Tullahoma, Tennessee 37388

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Name of Patient Giving Consent: _____

Address: _____ Social Security # _____

~~~~~~

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

~~~~~~

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities & healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities & healthcare operations, of the uses & disclosures we may make of your protected health information & of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, during business hours by request of any staff member.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent

I, _____, have had full opportunity to read and consider the contents of this Consent form & your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use & disclosure of my protected health information to carry out treatment, payment activities and health care operations.

~~~~~~

Signature: _____ Date: _____

Personal Representative's Name: _____

Relationship to Patient: _____

~~~~~~

Revocation of Consent: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and health care operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

You are entitled to a copy of this Consent after you sign it, available to you upon request.

GLICK & WOODS DENTISTRY
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 health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (08/21/13), 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 make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or 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.

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

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 incapacity or 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.

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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of 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).

PATIENT 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $10.00 per hour for staff time to locate and 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation 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: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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: Sandy Hodges Office Manager Telephone: 931-455-3917
Fax: 931-455-8167 E-mail: glicknwoods@lighttube.net
Address: 208 North Washington Street, Tullahoma, TN 37388

GLICK & WOODS DENTISTRY

208 North Washington Street
Tullahoma, Tennessee
931-455-3917

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of office's Notice of Privacy Practices.

Please Print Patients Name Please Print Your Name

Your Signature as Patient or Guardian 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)