PATIENT INFORMATION

Name ______________________ Home Phone ______________ e-mail ______________

Address ______________________ City ______________ Zip Code ______________

Employer ______________________ Present Position ______________________

Address ______________________ Business Phone ______________________

Name of Spouse ______________________ Business Phone ______________________

Employer ______________________ Address ______________________

REFERRED BY ______________________

IN CASE OF EMERGENCY *(Person not living with you)*

Name ______________________ Relationship ______________________

Address ______________________ Phone ______________________

FINANCIAL INFORMATION

Social Security Number ______________________ Driver's Lic. No. ______________ State ______ Expiration Date ______________

INSURANCE INFORMATION

Primary Carrier ______________________ Secondary Carrier ______________________

Address ______________________ Address ______________________

Name of Insured ______________________ Name of Insured ______________________

Policy Holder's Social Security No. ______________________ Policy Holder's Social Security No. ______________________

Group/Policy Number ______________ Date of Birth ______________ Group/Policy Number ______________ Date of Birth ______________

DENTAL HISTORY

1. Reason for this visit: ______________________
2. Previous dentist: ______________________ Date of last visit: ______________________
   Address: ______________________

	NO	YES	Doctor's Notes
3. Have you had any unusual or unpleasant experience in the dental office?	☐	☐	
4. Do you have pain in your teeth or gums?	☐	☐	
Jaw joint?	☐	☐	
Head or neck?	☐	☐	
5. Does your jaw click or pop?	☐	☐	
6. Have you had an injury to the face?	☐	☐	
7. Do you have difficulty opening your mouth wide?	☐	☐	
8. Have you had:			
Orthodontic treatment/braces?	☐	☐	
Tooth extraction?	☐	☐	
Oral surgery?	☐	☐	
Gum problems?	☐	☐	

I acknowledge full responsibility of services and agree to pay for them, in full, at the time of service unless arrangements are made with the office. In the event of default of payment I agree to be responsible for all attorney's fees and other court costs.

Signature ______________________ Date ______________________

11/99

Please answer all questions

MEDICAL HISTORY

		No	Yes	Doctor's Notes
1.	Date of birth ______			
2.	Are you under a physician's care now?	☐	☐	______
3.	Have you been hospitalized or had a serious illness?	☐	☐	______
4.	Are you taking any medication?	☐	☐	______
	If so, what? ______			
5.	Women: Are you pregnant?	☐	☐	______
	Do you have or have had any of the following:			
6.	Heart disease	☐	☐	______
7.	Chest pain, angina history, or heart attack	☐	☐	______
8.	Rheumatic fever or rheumatic heart disease	☐	☐	______
9.	Heart murmur / Fen/Phen use	☐	☐	______
10.	High blood pressure	☐	☐	______
11.	Stroke	☐	☐	______
12.	Fainting spells, convulsions, or epilepsy	☐	☐	______
13.	Nervous breakdown or emotional problems	☐	☐	______
14.	Lung disease (T.B., asthma, emphysema, bronchitis, etc.)	☐	☐	______
15.	Liver disease (hepatitis, jaundice, cirrhosis, etc.)	☐	☐	______
16.	Kidney disease	☐	☐	______
17.	Diabetes	☐	☐	______
18.	Prolonged bleeding or blood disorder	☐	☐	______
19.	Venereal disease (syphilis, gonorrhea)	☐	☐	______
20.	Immono suppression, A.I.D.S.	☐	☐	______
21.	X-ray, radiation, or other treatments for tumor	☐	☐	______
22.	Do you have any limitations regarding activity or diet?	☐	☐	______
	If so, what? ______			
23.	Have you had joint surgery or a prosthetic joint replacement?	☐	☐	______
24.	Have you become sick from, shown any allergy to, or been told not to take any of the following?			
	Penicillin or other antibiotics	☐	☐	______
	Aspirin, codeine, demerol, valium, or barbituates	☐	☐	______
	Novocaine, xylocaine, or other anæsthetics	☐	☐	______
	Other medications	☐	☐	______
25.	Is there anything of importance in your medical history that has not been asked? Explain please:			

DENTAL FEAR ASSESSMENT

1. If you had to go to the dentist tomorrow, how would you feel about it?
   ☐ a) I would look forward to it as a reasonably enjoyable experience. ☐ b) I wouldn't care one way or the other.
   ☐ c) I would be a little uneasy about it. ☐ d) I would be afraid that it would be unpleasant and painful.
   ☐ e) I would be very frightened of what the dentist might do.
2. When you are waiting in the dentist's office for your turn in the chair, how do you feel?
   ☐ a) Relaxed ☐ b) A little uneasy ☐ c) Tense ☐ d) Anxious
   ☐ e) So anxious that I sometimes break out in a sweat or almost feel physically sick.
3. When you are in the dentist's chair waiting while he/she gets his/her drill ready to begin working on your teeth, how do you feel?
   ☐ a) Relaxed ☐ b) A little uneasy ☐ c) Tense ☐ d) Anxious
   ☐ e) So anxious that I sometimes break out in a sweat or almost feel physically sick.
4. You are in the dentist's chair to have your teeth cleaned. While you are waiting the dentist is getting out the instruments which he/she will use to scrape your teeth around the gums. How do you feel?
   ☐ a) Relaxed ☐ b) A little uneasy ☐ c) Tense ☐ d) Anxious
   ☐ e) So anxious that I sometimes break out in a sweat or almost feel physically sick.

SOCIAL HISTORY

		No	Yes	
1.	Do you use tobacco?	☐	☐	If yes, how much? ______
2.	Do you drink alcohol?	☐	☐	If yes, how much / often ______
3.	Do you use other drugs?	☐	☐	If yes, what drugs? ______
4.	Do you exercise regularly?	☐	☐	______
5.	Are you under unusual stress?	☐	☐	______

Signature ______ Date ______

Melissa Tuft, D.D.S.

FINANCIAL AGREEMENT

Welcome to our practice and thank you in advance for choosing our office for your dental care. We are committed to providing excellent dental care with concern for your personal needs. The following information with acquaint you with our office financial policies and allow us to provide a high quality of service to you.

1. **Insurance Benefits**: We are happy to complete and submit your insurance forms on your behalf. We may also submit a "pre-treatment estimate to your insurance to provide you're out of pocket estimated expense and/or what your benefit level estimate will be for a certain procedure. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some of the services we provide may not be a covered benefit. We cannot guarantee the payment level that is quoted nor have information on benefits used in any other dental professional's office if used within your plan year. Any balances remaining after your insurance pays, are due within 15 days of billing.

2. **Minor Patients**: The adult accompanying the minor (under the age of 18) is responsible for full payment of the services provided, unless covered on parent's dental insurance plan. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.

3. **Missed Appointments**: For the courtesy of other patients that are waiting for appointment times, please be aware that we require a 24 hour notice to change or cancel an appointment to avoid a charge.

4. **Payment**: FULL PAYMENT and/or CO-PAYMENTS, DEDUCTIBLES are due at the time of service.

PAYMENT OPTIONS

1. We accept: **VISA, MASTERCARD, DISCOVER, AMX, CASH**, OR **CHECK**
2. **Care Credit** Financing: available upon approval of credit, we offer a 12 month interest free plan.

CONSENT FOR CARE

I request the consultation/treatment services of Dr. Melissa Tuft & Staff. I authorize the doctor/staff to take any necessary x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of treatment needs. I understand this may include consultation with my physician or other practice specialists. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

__________________________. ____.
DATE PATIENT SIGNATURE (Parent if under 18)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND DENTAL MATERIALS FACT SHEET. **↓Please initial below↓**

( ) I acknowledge that I have received or have read all information pertaining to my dentists Privacy Practice and Dental Facts Materials sheet.

Comparisons of Direct Restorative Dental Materials

COMPARATIVE FACTORS	TYPES OF DIRECT RESTORATIVE DENTAL MATERIALS: AMALGAM	COMPOSITE RESIN (DIRECT AND INDIRECT RESTORATIONS)	GLASS IONOMER CEMENT	RESIN-IONOMER CEMENT
General Description	Self-hardening mixture in varying percentages of a liquid mercury and silver-tin alloy powder.	Mixture of powdered glass and plastic resin; self-hardening or hardened by exposure to blue light.	Self-hardening mixture of glass and organic acid.	Mixture of glass and resin polymer and organic acid; self hardening by exposure to blue light.
Principle Uses	Fillings; sometimes for replacing portions of broken teeth.	Fillings, inlays, veneers, partial and complete crowns; sometimes for replacing portions of broken teeth.	Small fillings; cementing metal & porcelain/metal crowns, liners, temporary restorations.	Small fillings; cementing metal & porcelain/metal crowns, and liners.
Resistance to Further Decay	High; self-sealing characteristic helps resist recurrent decay; but recurrent decay around amalgam is difficult to detect in its early stages.	Moderate; recurrent decay is easily detected in early stages.	Low-Moderate; some resistance to decay may be imparted through fluoride release.	Low-Moderate; some resistance to decay may be imparted through fluoride release.
Estimated Durability (permanent teeth)	Durable	Strong, durable.	Non-stress bearing crown cement.	Non-stress bearing crown cement.
Relative Amount of Tooth Preserved	Fair; Requires removal of healthy tooth to be mechanically retained; No adhesive bond of amalgam to the tooth.	Excellent; bonds adhesively to healthy enamel and dentin.	Excellent; bonds adhesively to healthy enamel and dentin.	Excellent; bonds adhesively to healthy enamel and dentin.
Resistance to Surface Wear	Low Similar to dental enamel; brittle metal.	May wear slightly faster than dental enamel.	Poor in stress-bearing applications. Fair in non-stress bearing applications.	Poor in stress-bearing applications; Good in non-stress bearing applications.
Resistance to Fracture	Amalgam may fracture under stress; tooth around filling may fracture before the amalgam does.	Good resistance to fracture.	Brittle; low resistance to fracture but not recommended for stress-bearing restorations.	Tougher than glass ionomer; recommended for stress-bearing restorations in adults.
Resistance to Leakage	Good; self-sealing by surface corrosion; margins may chip over time,	Good if bonded to enamel; may show leakage over time when bonded to dentin; Does not corrode.	Moderate; tends to crack over time.	Good; adhesively bonds to resin, enamel, dentine/ post-insertion expansion may help seal the margins.
Resistance to Occlusal Stress	High; but lack of adhesion may weaken the remaining tooth.	Good to Excellent depending upon product used.	Poor; not recommended for stress-bearing restorations.	Moderate; not recommended to restore biting surfaces of adults; suitable for short-term primary teeth restorations.
Toxicity	Generally safe; occasional allergic reactions to metal components. However amalgams contain mercury. Mercury in its elemental form is toxic and as such is listed on prop 65.	Concerns about trace chemical release are not supported by research studies. Safe; no known toxicity documented. Contains some compounds listed on prop 65.	No known incompatibilities. Safe; no known toxicity documented.	No known incompatibilities. Safe; no known toxicity documented.
Allergic or Adverse Reactions	Rare; recommend that dentist evaluate patient to rule out metal allergies.	No documentation for allergic reactions was found.	No documentation for allergic reactions was found. Progressive roughening of the surface may predispose to plaque accumulation and periodontal disease.	No known documented allergic reactions; Surface may roughen slightly over time; predisposing to plaque accumulation and periodontal disease if the material contacts the gingival tissue.
Susceptibility to Post-Operative Sensitivity	Minimal; High thermal conductivity may promote temporary sensitivity to hot and cold; Contact with other metals may cause occasional and transient galvanic response.	Moderate; Material is sensitive to dentist's technique; Material shrinks slightly when hardened, and a poor seal may lead to bacterial leakage, recurrent decay and tooth hypersensitivity.	Low; material seals well and does not irritate pulp.	Low; material seals well and does not irritate pulp.

Esthetics (Appearance)	Very poor. Not tooth colored: initially silver-gray, gets darker, becoming black as it corrodes. May stain teeth dark brown or black over time.	Excellent ; often indistinguishable From natural tooth.	Good; tooth colored, varies in translucency .	Very good; more translucency than glass ionomer.
Frequency of Repair or Replacement	Low; replacement is usually due to fracture of the filling or the surrounding tooth.	Low-Moderate; durable material hardens rapidly; some composite materials show more rapid wear than amalgam. Replacement is usually due to marginal leakage.	Moderate; Slowly dissolves in mouth; easily dislodged.	Moderate; more resistant to dissolving than glass ionomer, but less than composite resin.
Relative Costs to Patient	Low, relatively inexpensive; actual cost of fillings depends upon their size.	Moderate; higher than amalgam fillings; actual cost of fillings depends upon their size; veneers & crowns cost more.	Moderate; similar to composite resin (not used for veneers and crowns).	Moderate; similar to composite resin (not used for veneers and crowns).
Number of Visits Required	Single visit (polishing may require a second visit)	Single visit for fillings; 2+ visits for indirect inlays, veneers and crowns.	Single visit.	Single visit.

MELISSA TUFT, D.D.S.

Aesthetics and Comfort

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 04/14/03, 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 $0.______ for each page, $______ 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: ______________________________

Telephone: ______________________ Fax: ______________________

E-mail: ______________________________

Address: ______________________________

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