MICHAEL J. TISDELLE, D.D.S.
2216 Ivy Road Suite # 205, Charlottesville, VA 22903
(434) 977-4101
www.drtisdelle.com

Date___________

Patient Information

Patient Name: ____ Nickname:________________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ________________________________ Birth Date:________________________________

Phone (Home): ________________ (Work): ________________ Ext:______ (Cell): ____________________

E-mail address:____

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

Date of **Last** Dental Visit: ___________________ Reason for **this visit**:________________________________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ___________ ___________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ **Heart Murmur**
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Currently Pregnant Due date:__________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ **Codeine Allergy**
- ☐ **Penicillin Allergy**
- ☐ **Latex Allergy**

OTHER:
- ☐ __________________
- ☐ __________________
- ☐ __________________

• Please list all current prescription and over-the-counter medications (including herbal supplements, vitamins and recreational non-prescription drugs):

____
____

• Name of Physician: ____ Phone:____________________

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:______________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Friend ☐ Relative ☐ Co-Worker

Name of person or office referring you to our practice:____

☐ Phonebook ☐ Insurance company ☐ Dr. Michael Tisdelle's Office Website
☐ Internet Search engine (Cirle one): Bing – Facebook - Google – Yelp -Yahoo - Other:____________________

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________________

Address: ____

Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's Birth Date: __________ ID #: __________ Group #: __________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________

Insurance Plan Name and Address: ____

____

____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other __________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): __________ (Work): __________ Ext: ______ Best time to call: __________

Address: ____

Street Apartment #

____

City State Zip Code

Consent for Treatment

I hereby authorize doctor or designated staff to take x-rays, models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of all (patient)'s dental needs. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risk.

______________________ Date: __________ Relationship to Patient: __________

Signature of patient, parent, or guardian

Emergency Contact Information (must be over age 18)

Name: ______________________ Relationship to Patient: __________

Phone – (Cell): __________ (Work): __________ (Home): __________

DENTAL HISTORY

Patient Name: ____________________________ **Medical Alert:** ___________________________

Welcome! *So that we may provide you with the best possible care, please complete this dental history form. All information is completely confidential.*

How often do you have dental examinations: ____
How often do you brush your teeth? ___________________How often do you floss? _______________
What other dental aids do you use? (Interplak, toothpick, etc.) _________________________________

Are any of your teeth sensitive to:

Hot or Cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesion? Yes No

Have you ever had:

Orthodontic treatment/"braces"?: Yes No
Oral Surgery/extractions?: Yes No
Periodontal Treatment/"gums"?: Yes No
Your teeth ground or the bite adjusted?: Yes No
A serious injury to the mouth or head?: Yes No
If yes, please describe: ______________
____

Do your gums bleed or hurt? Yes No
Have your parents experienced Gum disease or tooth loss?: Yes No
Have you noticed any loose teeth Or change in your bite?: Yes No
Does food tend to become caught In between your teeth?: Yes No
If yes, where? ________________
____

Have you experienced:

Clicking or popping of the jaw?: Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty opening or closing mouth?: Yes No
Difficulty chewing on either side of the mouth?: Yes No
Headaches, neckaches or shoulder aches?: Yes No
Sore muscles (neck, shoulders)?: Yes No

Do you:

Clench or grind your teeth while Awake or asleep?: Yes No
Bite your lips or cheeks regularly?: Yes No
Hold foreign objects with your Teeth (pencils, pipe, pins, nails, Fingernails) Yes No
Mouth breathe while awake or Asleep?: Yes No
Have tired jaws, especially in The morning?: Yes No
Smoke/chew tobacco?: Yes No

Are you satisfied with your teeth's appearance?: Yes No

Would you like to keep all of your teeth all of your life?: Yes No
Do you feel nervous about having dental treatment?: Yes No
If so, what is your biggest concern?
____
Have you ever had an upsetting dental experience?: Yes No
If yes, please describe _____________
____
____

Is there anything else about having dental treatment that you would like us to know?: Yes No
If yes, please describe ____
____

Michael J. Tisdelle, D.D.S.

As a condition of your treatment by this office, financial arrangements must be made in advance. Our practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

For patients that have dental insurance, we will be happy to file a claim for you. Please furnish us with the necessary forms, information and your signature for assignment of benefits. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to your account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

If we have not received payment from your insurance company within 60 days of billing, that portion of the bill will be due from you. Please help us by contacting your insurance company or agent to assure prompt payment. Any portion of the charges not covered by insurance or co-payment is considered due and payable at the time of service.

A service charge of 1 ½ % per month (18 % per year) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fees estimated for any dental care, if unaccepted on the date of the patient examination, are subject to any fee schedule changes from that original date.

In consideration for the professional services rendered to me, I agree to pay my portion at the time the services are rendered. In the event that it becomes necessary to turn my account over to an outside agency for collection, I further agree to assume responsibility to pay all collection fees (including 25 % agency fee), attorney fees and other court costs.

I hereby authorize my insurance benefits be paid directly to Michael J. Tisdelle, D.D.S., and I am financially responsible for any non-covered services. In the event that an "alternate benefit provision" is applied by the insurance company and the dentist and member choose a more expensive treatment option, the member is responsible for the additional charges beyond the allowance for the alternate procedure. I also authorize the release of any information required to process this claim.

I have read the above conditions of treatment and agree to their content.

Patient Signature: ____

Parent/Guardian Signature: ______________________________________

Relationship to Patient: ____

Date: ____

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Michael J. Tisdelle, DDS

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 $0.99 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: Pat Tisdelle, Office Manager

Telephone: (434) 977-4101 Fax: (434) 963-7856

E-mail: info@drtisdelle.com Address: 2216 Ivy Road, Suite # 205 Charlottesville, VA 22903

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Michael J. Tisdelle, DDS

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.

____
{Please Print Name}

____
{Signature}

____
{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)

____

____

© 2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).