EMERGENCY DENTAL CARE

Matt Stunkel, D.D.S.

1440 W. Republic Road Suite 144 Springfield, MO 65807
Phone: (417) 720-4075 Fax: (417) 501-1147

Today's date:_____

Patient's Name: Sex: M F **BIRTHDATE:** Age:

Home Address: City: State: ZIP:

Soc. Sec. #: Home Ph#: Cell Ph#:

If patient is a minor: Mother's name/DOB: Father name/DOB:

Name of Spouse (if applicable): Emergency Contact Name/Ph#:

Patient's Employer Name/Ph#: Patient's Occupation:

How did you hear about our office? **Email Address:**

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder's Name:

Policy Holder's DOB:

Policy Holder's Employer:

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Policy Holder's SSN or ID#:

Group #:

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder's Name:

Policy Holder's DOB:

Policy Holder's Employer:

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Policy Holder's SSN or ID#:

Group #:

FINANCIAL POLICY

The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa and Discover. Outside financing is available upon request and approval.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.
- You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance.

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

Photo Release: I give Quail Creek Dental (QCD) the right to use my name, photo, image or voice in all forms for promotion of QCD or media coverage of QCD and its events with no monetary compensation to myself

Appointment Policy: **A notice of 48 hours must be given for cancellation or rescheduling of appointments. This is the Quail Creek Dental appointment policy, and the policy cannot be changed. A minimum fee of $50 will be charged, however; a fee of up to 100% of your scheduled appointment amount may be charged TO YOU, for last minute cancellations or No Show appointments.**

Patient Signature (Parent if child)_____ **Date**_____

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HIPAA CONSENT FORM

Patient Name (please print):_____ Date:_____

Patient DOB:_____

HIPAA- Notice of Privacy Practices
HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the notice Privacy Practice is to explain how Matt Stunkel, D.D.S. may use or disclose your healthcare information. The notice also explains the rights that you are guaranteed under HIPAA regulations. Matt Stunkel, D.D.S. is required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Signing below indicates that you have received the Notice of Privacy Practices. I hereby acknowledge that I have received or requested to receive a copy of Matt Stunkel, D.D.S. Notice of Privacy Practices.

_____
Patient Signature (or Guardian)

Permission to Share Medical/Dental Information:

(Including a spouse; optional- **you may leave this section blank)**

My medical/dental information may be obtained and/or exchanged written or verbally to:

_____
(Printed Name and Relationship)

_____ _____
Patient Signature (or Guardian) Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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MEDICAL HEALTH HISTORY

PATIENT NAME:_____

Do you have or have you had any of the following?
(Please check any that apply- or NONE)

- ❑ Cancer Type:_____
- ❑ Tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis Type:_____
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes Type:_____
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Asthma
- ❑ NONE

Are you currently taking any of the following?
(Please check any that apply- or NONE)

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)drug name(s) ↓

_____

- ❑ Antibiotics or sulfa drugs: drug name(s) ↓

_____

- ❑ High blood pressure medicine(s) drug name(s) ↓

_____

- ❑ Antidepressants or tranquilizers drug name(s) ↓

_____

- ❑ Insulin or other diabetes drug name(s) ↓

_____

- ❑ Other:_____

_____

- ❑ NONE

Name and Phone Number of your physician: _____

Do you have any disease, condition, or problem not listed above?_____

Women:

Pregnant: YES / NO Expected delivery date:_____Recently Delivered~ Date of Delivery:_____

Are you allergic or have you reacted adversely to any of the following medications?
(Check all that apply or NONE)

- ☐ Aspirin
- ☐ Nitrous Oxide
- ☐ Percocet
- ☐ Norco
- ☐ Latex
- ☐ Local Anesthetic:
  Name/Type_____
- ☐ Codeine
- ☐ Azithromycin
- ☐ Clindamycin
- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil/Motrin)
- ☐ Valium
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Sulfa
- ☐ Other: _____
- ☐ NONE

_____ _____
Patient Signature (or Guardian) **Date**

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DENTAL HEALTH HISTORY

PATIENT NAME: _____

Primary reason for this dental appointment: _____

What would you like to improve about your dental health or smile? _____

Are you interested in straightening your teeth or closing any spaces? _____

Date of your last dental cleaning: _____ Date of last x-rays: _____

Please check any of the following that apply:

- ☐ Sensitivity (circle) hot; cold, sweet, pressure
  - Where? Upper R, Lower R, Upper L, Lower L For how long? _____

Do you have, or have you ever had any of the following: (only check the ones that apply)

- ☐ Do you smoke or use chewing tobacco?
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

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I have been informed of the appointment policy

_____
Patient Signature (or Guardian)

Consent:
The undersigned herby authorizes Doctor or Doctor's represenative to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

_____ _____
Patient Signature (or Guardian) **Date**

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Matt Stunkel, D.D.S.
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HIPAA 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 04-01-2013, 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 us99 a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $50.00 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: Dr. Matt Stunkel Telephone: 417-720-4075 Fax: 417-501-1147

E-mail: QuailCreekDental@GMAIL.com

Address: 1440 W. Republic Road #144 Springfield, MO 65807