Welcome to Brooklin Byrd, DDS

GENERAL INFORMATION

Name: _____ Today's Date: _____
Birthdate: _____ Social Security #: _____
Contact Phone: _____ Email: _____

REFERRAL INFORMATION

How did you hear about us?
❑ From another patient: _____
❑ From a staff member: _____
❑ Facebook ❑ Website
❑ From an advertisement: _____
❑ Other: _____

DENTAL HISTORY

Previous Dentist: _____ Date of last dental exam: _____
Have you had dental X-rays in the last year? ❑Yes ❑No
Are you nervous about dental treatment? ❑Yes ❑No
How many times a day do you brush? _____ Floss? _____
What type of toothbrush bristles do you use? ❑Soft ❑ Medium ❑ Hard
How would you rate your smile? (worst) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (best)

TODAY'S VISIT

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation
Are you in pain? ❑ Yes ❑ No If yes, for how long? _____
Please check the box if you currently have any of the following conditions:

❑ Discomfort, clicking, or popping of jaws
❑ Blisters/sores in or around mouth
❑ Red, swollen, or bleeding gums
❑ Sensitive tooth, teeth, or gums
❑ Lost/broken filling(s)
❑ Bad breath
❑ Ringing in ears
❑ Broken/chipped tooth
❑ Locking jaw
❑ Teeth grinding
❑ Stained teeth
❑ Other: _____

Do you use tobacco? ❑ Yes ❑ No
Form used? _____ How much? _____ How long? _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relation: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Who is your medical doctor?
_____

Medical Doctor's Phone:
_____

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the office manager. If account is not paid within the specified time frame and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account. I authorize the staff to perform any services needed during diagnosis and treatment. I authorize the provider to release any information required to process insurance claims or to refer for specialty treatment. I understand the above information and certify this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____

❑ Patient ❑ Parent or Guardian ❑ Spouse

MEDICAL HISTORY

Please check the box if you currently **have** or **have had** any of the following:

- ❑ AIDS/HIV/ARC positive
- ❑ Alzheimer's disease
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis/gout
- ❑ Artificial bones/joints
- ❑ Artificial valves
- ❑ Asthma/difficulty breathing
- ❑ Back problems
- ❑ Blood disease
- ❑ Blood transfusion
- ❑ Breathing problems
- ❑ Bruise easily
- ❑ Cancer/tumors
- ❑ Chemotherapy
- ❑ Chest pains/angina
- ❑ Cold sores/fever blisters
- ❑ Congenital heart defect/disorder
- ❑ Cortisone medicine
- ❑ Cosmetic surgery
- ❑ Diabetes/hypoglycemia
- ❑ Drug/alcohol addiction
- ❑ Emphysema
- ❑ Epilepsy/seizures/fainting
- ❑ Excessive bleeding
- ❑ Excessive thirst
- ❑ Fainting spells/dizziness
- ❑ Frequent cough
- ❑ Frequent diarrhea
- ❑ Glaucoma
- ❑ Hay fever
- ❑ Headaches frequently
- ❑ Heart attack/stroke
- ❑ Heart disease/trouble
- ❑ Heart murmur
- ❑ Heart pacemaker/surgery
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Herpes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hives/rash
- ❑ Hypoglycemia
- ❑ Irregular heartbeat
- ❑ Kidney problems
- ❑ Leukemia
- ❑ Liver disease
- ❑ Low blood pressure
- ❑ Lung disease
- ❑ Mitral valve prolapse
- ❑ Neck pain frequently
- ❑ Osteoporosis
- ❑ Pain in jaw joints/TMJ/TMD
- ❑ Parathyroid disease
- ❑ Psychiatric care
- ❑ Radiation/cobalt treatments
- ❑ Renal dialysis
- ❑ Respiratory problems
- ❑ Rheumatic fever
- ❑ Rheumatism/arthritis
- ❑ Scarlet fever
- ❑ Shingles
- ❑ Sickle cell disease
- ❑ Sinus trouble
- ❑ Spina bifida
- ❑ Stomach/intestinal disease
- ❑ Swelling of limbs
- ❑ Thyroid disease
- ❑ Tonsillitis
- ❑ Tuberculosis/TB
- ❑ Tumors/growths
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Yellow jaundice
- ❑ Other conditions or surgeries: _____

What medications are you taking?

❑ Tranquilizers ❑ Blood thinners ❑ Stimulants ❑ Muscle relaxers
❑ Insulin ❑ Medications/injections for osteoporosis (now or within the last 7 years)
❑ Nerve pills ❑ Pain killers (including aspirin)

Please list ALL medications you are taking:

Do you require antibiotic pre-medication? ❑ Yes ❑ No

Are you allergic to any of the following? ❑ Latex ❑ Tetracycline ❑ Foods
❑ Dental anesthetics ❑ Penicillin ❑ Aspirin ❑ Other: _____

For women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No If so, how far along?_____

Are you nursing? ❑ Yes ❑ No

I understand the above information and certify this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____

❑ Patient ❑ Parent or Guardian ❑ Spouse

Brooklin Byrd, 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.

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 12/02/20 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. 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 practices, 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 healthcare 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 specific confidentiality protections under applicable state or federal law. We will abide by the 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 determination 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 healthcare 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.

Public Health Activities. We may 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.

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

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, counter intelligence, and other national security activities. We may disclose to correctional institution or law-enforcement officials 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 your 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 healthcare system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you were 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 such 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 will 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 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 base 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 fee 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 healthcare 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.

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 payment 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 location 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 records and notify you of such. If we deny 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 toa 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 an alternative location, 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 anyway if you choose to file a complaint with us or with the US Department of Health and Human Services.

Our Privacy Official: Dr. Brooklin Byrd

Telephone: 901-386-3702

Fax: 901-380-0802

Address: 6405 Stage Road, Bartlett, TN 38134

Email: dentist@drbrooklinbyrd.com

Consent for Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

Email: _____

Section B: 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, and 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, and healthcare operations, of the uses and disclosures we may make of your protected health information, and 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 the 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 to our notice, at any time by contacting:

Contact Person: Dr. Brooklin Byrd
Email: emaildrbyrd@gmail.com
Telephone: 901-386-3702
Fax: 901-380-0802
Address: 6405 Stage Road, Bartlett, TN 38134

Right to revoke: You will have the right to revoke this consent at any time by giving us a written notice of a revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received a 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 and your notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

SIGNATURE: _____ **DATE**: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's notice of privacy practices.

Name (printed): _____

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 acknowledgment
- ❑ Other (please specify): _____

Brooklin Byrd, DDS

Consent to Receive Text Messages and or Email Messages

The team at Brooklin Byrd, DDS, LLC is implementing improved communication channels through text messaging and emails to stay in touch with patients. Sending patients text messages and emails will provide better ways for communication with office staff and Dr. Byrd, enabling patients to easily be informed of appointment reminders for procedures and regular care appointments and enabling patients to address any questions or concerns.

By signing below, I authorize Brooklin Byrd, DDS, LLC and its associated employees to contact me by phone, SMS text messaging, and/or email communication for dental health-related notifications. I understand that I will be able to respond to the communications sent either by replying to texts or to emails received.

I understand that message/data rates may apply to text messages sent by Brooklin Byrd, DDS, LLC under my cell phone plan. I know that I am under no obligation to authorize Brooklin Byrd, DDS, LLC to send me text messages or emails.

I may opt-out of receiving these communications at any time by calling the main telephone number (901-386-3702) and speak with office personnel or by replying "STOP" to texts or emails.

I understand that text messages and emails are not a substitute for professional medical attention. Brooklin Byrd, DDS, LLC respects the privacy of our patients. We will not share or sell any personal or confidential information in these texts or emails with unauthorized parties.

By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging and email services.

☐ Yes, I would like to receive *TEXT MESSAGES ONLY*

☐ Yes, I would like to receive *EMAILS ONLY*

☐ Yes, I would like to receive both *TEXT MESSAGES AND EMAILS*

☐ No, I prefer a phone call for communications and give my permission for office staff to leave a message if I am unable to take the call.

Cell phone number to text: _____

Email address: _____

Patient Name: _____

Signature: _____

❑ Patient ❑ Parent or Guardian ❑ Spouse

Date: _____

Consent to Dental Photography/Media Use

I, _____ (patient), authorize Brooklin Byrd, DDS, LLC and its associates to take photographs and/or videos of my face, jaws and teeth, before, during, and after treatment.

I consent to allow the photographs to be used for the following:

- *Dental Records*
- *Dental Research*
- *Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books*
- *Marketing material, including but not limited to websites, television, social media, and printed materials*
- *Patient education*

I further understand that if the photographs and/or videos are used, my name will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs or videos.

Signature: _____

❑ Patient ❑ Parent or Guardian ❑ Spouse

Date: _____

Brooklin Byrd, DDS

Insurance Information Form

GENERAL INFORMATION

Name: _____ Today's Date: _____
Birthdate: _____ Age: _____ Social Security #: _____
Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____
How long have you lived there? _____ Home Phone: _____
Cell Phone: _____ Work Phone: _____
Employer: _____ How long have you worked there? _____
Employer Address: _____
Status: ❑ Single ❑ Divorced ❑ Minor Spouse's Name: _____
❑ Married ❑ Separated ❑ Widowed
Do you have children? ❑ Yes ❑ No If so, how many? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____
Address: _____
Driver's License #: _____ Birthdate: _____ SSN: _____
Employer: _____ Work Phone: _____
Is this person currently a patient in our office? ❑ Yes ❑ No

INSURANCE INFORMATION

Name of insured: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____
Employer: _____ Date employed: _____
Employer address: _____ Work Phone: _____
City: _____ State: _____ Zip code: _____
Insurance co: _____ Ins. phone: _____
Ins. co. address: _____ Ins. policy #: _____
City: _____ State: _____ Zip code: _____
Deductible amount? _____ Total used? _____ Max annual benefit? _____

Do you have additional insurance? ❑ Yes ❑ No ***If yes, complete the following:***

Name of insured: _____ Birthdate: _____
Relationship to patient: _____ Social Security #: _____
Employer: _____ Date employed: _____
Employer address: _____ Work Phone: _____
City: _____ State: _____ Zip code: _____
Insurance co: _____ Ins. phone: _____
Ins. co. address: _____ Ins. policy #: _____
City: _____ State: _____ Zip code: _____
Deductible amount? _____ Total used? _____ Max annual benefit? _____

Signature: _____ **Date:** _____

❑ Patient ❑ Parent or Guardian ❑ Spouse