

# Welcome to Brooklin Byrd, DDS

## GENERAL INFORMATION

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

## RESPONSIBLE PARTY

Name of Person Responsible for this Account: \_\_\_\_\_  
Address: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Name of insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Insurance co: \_\_\_\_\_ Ins. phone: \_\_\_\_\_  
Ins. co. City: \_\_\_\_\_ Ins. co. State: \_\_\_\_\_ Ins. policy #: \_\_\_\_\_

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

## INSURANCE INFORMATION

Name of insured: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Insurance co: \_\_\_\_\_ Ins. phone: \_\_\_\_\_  
Ins. co. city: \_\_\_\_\_ Ins. co. state: \_\_\_\_\_ Ins. policy #: \_\_\_\_\_

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:

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

Please list ALL medications you are taking: \_\_\_\_\_

Do you require antibiotic pre-medication?  Yes  No

Have you ever taken medications/injections for osteoporosis ( such as bisphosphonates)?  Yes  No

Are you currently taking any blood thinners?  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

## EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Your medical doctor: \_\_\_\_\_

Medical Doctor's Phone: \_\_\_\_\_

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

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Patient

Parent or Guardian

Spouse



Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy. Please read and sign at the bottom acknowledging the following:

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand any treatment fee will be honored up to 90 days from the date of examination.

I understand **payment is due at time of service** unless prior arrangements are made with the financial coordinator.

As a courtesy to me, I understand this office will file any dental insurance for me. I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay for services, I agree to pay the full remaining balance. I understand this office will always try to help me maximize my dental benefits; however, ultimate responsibility for payment is mine and I am obligated and agree to pay this office for all charges incurred.

There will be a \$35 processing charge for non-sufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred in the collection.

There will be a no-show fee of \$75 assessed if an appointment is not rescheduled 48 hours prior to the scheduled appointment.

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient       Parent or Guardian       Spouse

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## COMMUNICATIONS POLICY

The team at Brooklin Byrd, DDS, LLC has implemented improved communications, enabling patients to easily be informed of appointment reminders and enabling patients to address any questions or concerns via text and email in addition to calling.

By signing, I authorize Brooklin Byrd, DDS, LLC and its associated employees to contact me by phone, SMS text messaging, and/or email for dental health-related notifications. I understand that message/data rates may apply to texts sent and received under my cell phone plan. I understand I am under no obligation to authorize Brooklin Byrd DDS, LLC to send me text messages or emails.

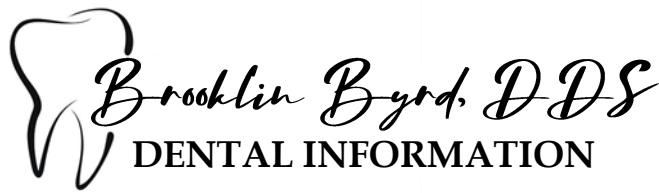
I may opt out of communications at any time by calling the main number (901-386-3702) and speak with office personnel or by replying "STOP" to texts/emails.

I understand text messages and emails are not a substitute for professional medical attention.

By signing below, I indicate I am the person legally responsible for 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 text messaging and email services.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient       Parent or Guardian       Spouse



### REFERRAL INFORMATION

How did you hear about us?

- From another patient: \_\_\_\_\_  Facebook or website  
 From a staff member: \_\_\_\_\_  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  Lost/broken filling(s)  Locking jaw  
 Blisters/sores in or around mouth  Bad breath  Teeth grinding  
 Red, swollen, or bleeding gums  Ringing in ears  Stained teeth  
 Sensitive tooth, teeth, or gums  Broken/chipped tooth  Other: \_\_\_\_\_

Do you use tobacco?  Yes  No

Form used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

### PHOTOGRAPHY POLICY

I, 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, and 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.

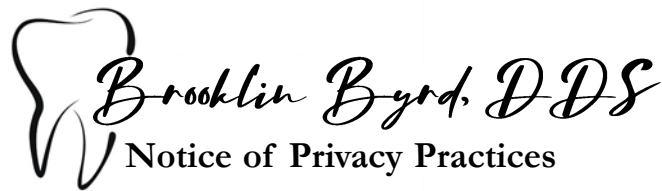
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient

Parent or Guardian

Spouse



**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.

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## 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 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 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.

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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

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](mailto: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: \_\_\_\_\_

Patient

Parent or Guardian

Spouse



## Insurance Policy

We DO NOT work for an insurance company. We work 100% for our patients and have their best interest in mind. Most insurance companies provide benefits for our patients and we will do everything we can to maximize your benefits. However, please understand that the fees that we charge and the treatment that we recommend is specifically designed for your individual needs and is NEVER based on your insurance coverage.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_