Medical History Form Date _____/_____/_____

Name _____ _____ _____ Home Phone (____) _____
Last First Middle
Local Address _____Apt # _____ Work Phone (____) _____

City _____ State _____ Zip Code _____ Cell Phone (____) _____

E-Mail Address_____ Social Security # _____

Sex M F Date of Birth ___/___/___ Height _____Weight_____Married _____Single _____Child _____Other _____

Name of Spouse _____Emergency contact _____ Phone (____) _____
I authorize Dr. Kindt's office to contact and release information to my spouse/closest relative stated above.

Other Family Members Currently Patients? _____

Whom may we thank for referring you to our practice?
Name of person or office referring you to our practice: _____
____Dental Office _____Website ____Coworker ____ Insurance List Other _____ _____

Health Information
Your answers are for our records only and will be considered confidential. Please note that during your exam you will be asked some questions about your responses and there may be additional questions concerning your health.

Have you ever been diagnosed or had any of the following?
Please check all that apply.

___ Aids+/HIV
___ Allergies Food/Seasonal
___ _____
___ Anemia
___ Arthritis
___ Artificial Joints:
Year_____ Joint_____
___ Asthma
___ Blood Disease
___ Blood Transfusion
___ Cancer
___ Cardiovascular Disease
___ CPAP
___ Diabetes: Type _____
___ Difficulty Breathing
___ Dizziness
___ Drug/Alcohol Abuse
___ Epilepsy/Seizures
___ Excessive Bleeding
___ Fainting
___ Glaucoma
___ Hay Fever
___ Head Injuries: Year_____
___ Heart Murmur
___ Hepatitis: Type _____
___ High Blood Pressure
___ Hyper/Hypo Thyroid (**circle 1)**
___ Jaundice
___ Kidney Disease
___ Liver Disease
___ Low Blood Pressure
___ Mental Disorders
___ Mitral Valve Prolapse
___ Nervous Disorders
___ Pacemaker: Year_____
___ Pregnant: Due Date _____
___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Sinus Problems
___ Smoking/ Tobacco
___ Snoring
___ STD: _____
___ Stomach Problems
___ Stroke
___ Tuberculosis
___ Tumors
___ Ulcers

Are you allergic to:
Codeine Aspirin
Local Anesthetics Iodine
Sulfa Drugs Penicillin
Other _____
_____

Do you have any disease, condition, or problem not listed above that you think I should know about?
Yes No Please explain:_____
_

Do you require any pre-medications prior to dental treatment? Yes No
Are you wearing removable dental appliances? Yes No

Are you taking any medicine(s) including non-prescription medicine, drugs or alcohol? Yes No
What medicine(s) are you taking?_____
_____
_____

Have you been under the care of a physician in the last 6 months? Yes No
If yes please explain: _____
Physician's name and number _____

Have you been admitted to a hospital or needed emergency care during the past five years? Yes No
Please explain:_____

Responsible Party Information

Name: _____ Male / Female Relationship to Patient: _____
Social Security #_____ Birth Date _____/_____/_____
Phone (home): _____Work: _____ Ext: _____ Cell: _____
Address: _____City:_____State:_____ Zip_____

Patient Employment Information
Subscriber's Employer Name _____Phone Number: _____
Address: _____City: _____State: _____Zip:_____

Primary Insurance Information

Name of subscriber: _____ is insured a patient? Yes No
Subscriber Birth Date: _____/_____/_____ SSN _____
Subscriber's Employer Name _____Phone Number: _____
Address: _____City: _____State: _____Zip:_____
Insurance Company: _____ Phone_____Group #: _____
Address: _____City: _____State: _____Zip: _____

Secondary Insurance Information

Name of subscriber: _____ is insured a patient? Yes No
Subscriber Birth Date: _____/_____/_____ SSN _____
Subscriber's Employer Name _____Phone Number: _____
Address: _____City: _____State: _____Zip:_____
Insurance Company: _____ Phone_____Group #: _____
Address: _____City: _____State: _____Zip: _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Kindt D.D.S.

_____ _____
Signature (Employee/subscriber) Date

Consent For Services
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Kindt or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this medical history form.

I give my consent for dental treatment that the doctor indicates on the examination chart and any other dental treatment deemed necessary or advisable as a corollary to the planned dental treatment. I have been advised of all probable complications of the dental treatment.

If patient is a minor, I hereby grant permission for dental treatment to be performed on this minor and will assume all responsibilities connected with such treatment.

I understand that I am financially responsible for dental fees, with or without insurance payment.

I hereby authorize any insurance company to release all information with bearing on the benefits payable under this or any other plan providing benefits ore services.

Signature of Patient or Parent if minor _____ Date _____/_____/_____

Dr. Kindt Signature _____

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

Due to the HIPAA laws that are now in effect we must have your written authorization to release your medical information to a person other than yourself. Understand that your information may need to be discussed with your current physician and/or referred to/or/ from specialists in regards to scheduling of procedures, consultations and health history that may impact your dental health. Only the information needed to do this will be released. This release will be valid for one year from the date of signing.

1. Who may we release your medical information to:

   A) Spouse_____ B) Sibling_____ C) Parent_____

   D) Son/ Daughter_____ E) Other) _____
   Please give name of person

   F) Doctors Office_____ F) Insurance Company_____

2. May we send reminder postcards through the mail and or e-mail?

   Yes_____ No_____

3. May we leave a message on your answering machine, text or by e-mail to confirm dental appointments, discuss dental treatment and account balance ?

   Yes_____ No_____

Print Pt. Name _____ Signature_____

Date _____

FINANCIAL POLICY

In our continued efforts to provide you with the best dental care possible and to provide our services at reasonable rates, we are pleased to offer the following methods of payments:

1. Cash or Check
2. Visa, MC, Discover and American Express
3. Extended payment plan through financing *deferred interest*.(O.A.C.)
   Care Credit

PATIENT LIABILITY

- Entire cost of dental treatment
- Deductibles and your portion according to your insurance coverage

Insurance is a contract between you, your insurance company, and your employer. As a courtesy, we will bill your insurance after coverage has been verified. However, deductibles and co-insurance amounts are due at the time of treatment. We cannot guarantee your insurance coverage. We will give you an **estimate** only on the treatment that is diagnosed.

We are happy to accept assignment of insurance benefits. Any patient balance that is not paid within 60 days, we will require a credit card on file for future treatment.
_____Initial

If you have any questions regarding your bill, please ask or call our office at 480-981-0094.

I have read, understand and agree to the above Financial Policy. I am aware that I am fully responsible for all costs regardless of insurance coverage. In the event that payment is not made on this account it will be reported to a credit bureau. Should legal action be necessary to collect the account, I/We agree to pay all fees incurred while trying to collect on this account.

Patient Name _____ Date _____
(Please Print)

Responsible Party _____ Date _____
(Signature)

PRIVACY PRACTICES ACKNOWLEDGEMENT
Office Copy

Privacy Notice Amendment September 2013
I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

_____ _____
Patient signature Date

_____ _____
Practice witness Date

I authorize the following person(s) to have access to my dental records/information:

_____, relationship _____

_____, relationship _____

Dr. Timothy H. Kindt DDS
1244 N. Greenfield Rd #105
Mesa, Az 85205
OFFICE USE ONLY

Refusal to Sign Form Acknowledgement
____ **Patient/Responsible Party Refused to sign form**

_____ _____
Practice Witness #1 **Practice Witness #2**

Privacy Contact: Alyce Watkins
1244 N. Greenfield Rd #105
Mesa, Az 85205
480-981-0094

Dr Timothy H. Kindt DDS
1244 N. Greenfield Rd #105
Mesa, Az 85205
480-981-0094

NOTICE OF PRIVACY PRACTICES

This notice takes effect September 2013 and will remain in effect until we replace it. It describes how health information about you may be used and disclosed by our practice and how you can obtain 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. Our privacy practices are developed to meet requirements as specified by law. If the law changes we will amend our privacy practices to reflect the changes in the law. We must follow the privacy practices that are described in this Notice while it is in effect. 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 laws, 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, inform you of changes in the Notice by getting a new signed copy from you, and we will provide copies of the new Notice upon request. 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 health care 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 special confidentiality protections under applicable state or federal law. We will abide by these 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, or to a care provider that is overseeing other health needs you may have.

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 determinations 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, or we could require a 3rd party to aid in collection of unpaid balances that are due.

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 health care 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.

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

Public Health Activities. We may disclose your health information for public health activities as required by law, 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.

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 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 personal health information 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 personal health information 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 personal health information 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 programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your personal health information 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 personal health information 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. It should however be noted that we typically do not participate in research projects and this release is unlikely.

Coroners, Medical Examiners, and Funeral Directors. We may release your personal health information 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 personal health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. By law, 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 fundraising communications. Our office policy is to NOT fundraise with patient information.

Other Uses and Disclosures of Personal Health Information. If a situation arises that is not covered in the prior sections, we will seek your permission for health information disclosure, unless dictated to do so by law. Your privacy is important to us and we work hard to secure all patient health information to protect individual privacy.

YOUR HEALTH CARE 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 us 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 still have the right to receive a printed, or if possible, an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based 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 any 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 person health information 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 health care 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 payments 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 locations you have requested we may contact you using the information we have on file.

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 record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we decided 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 Web site or by electronic mail (e-mail).

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 strict 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 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.