OVER THE MOUNTAIN
FAMILY AND COSMETIC DENTISTRY

WELCOME!

We are pleased to welcome you to our practice. Please complete this form as accurately as possible. If you have questions we'll be glad to assist you. We look forward to working with you to maintain your dental health.

Patient's name _____

Preferred name _____ Birth Date _____ SSN _____

If minor, guardians' names _____

Sex____ Age ____ Single __ Married __ Widowed __ Separated __ Divorced __

Mailing address _____ Apt. or Suite #_____

City _____State _____ Zip _____

Home phone _____ Cell Phone _____

Email Address _____

Employer _____

Business Address _____

Occupation _____ Business Phone _____

Spouse's name _____

Spouse's employer _____

Whom may we thank for referring you to our office? _____

Who should we notify in case of emergency? (Name and phone) _____

_____

MEDICAL HISTORY

*** OVER THE MOUNTAIN DENTISTRY ***

2850 Cahaba Road, Suite #140 * Birmingham, Alabama * 35223 * 205.968.1296

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Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important impact on the dentistry you receive. Please answer the following questions carefully and thoroughly.

Please list all prescription medications as well as over-the counter vitamins, supplements and medications you are currently taking:

_____
_____
_____
_____

CIRCLE IF YOU NOW HAVE, OR HAVE EVER HAD, ANY OF THE FOLLOWING:

AIDS or HIV+
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Bacterial Endocarditis
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Cardiac Pacemaker
Chemotherapy
Chest Pains
Cold Sores
Congenital Heart Disease
Convulsions
Cortisone Medicine
Diabetes
Drug Addictions
Easily Winded
Emphysema
Epilepsy/Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells
Fever Blisters
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Gout
Hay Fever/Allergies
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
High Blood Pressure
Hives or Rash
Hypertrophic Cardiomyopathy
Hypoglycemia
Irregular Heartbeat
Jaundice
Joint Replacement
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain in Jaw Joints
Parathyroid Disease
Prosthetic Heart Valves
Psychiatric Care
Pulmonary Shunt
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Respiratory Problems
Rheumatic Heart Disease
Rheumatism
Scarlet Fever
Sexually Transmitted Disease
Shingles
Sickle Cell Anemia
Sinus Trouble
Spina Bifida
Stomach Problems/Ulcers
Stroke
Swelling of Limbs
Thyroid Problems
Tonsillitis
Tuberculosis
Tumors or Growth

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Have you ever been hospitalized or had a major operation? **Yes/No** If yes, please explain

_____

_____

Have you ever had a serious head or neck injury? **Yes/No** If yes, please explain

_____

Are you on a special diet? **Yes/No** If yes, please explain

_____

Do you use tobacco? **Yes/No** If yes, please explain

_____

Do you use controlled substances? **Yes/No** If yes, please explain

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Please circle: Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other
If other, please explain

_____

WOMEN: Pregnant/Trying to become pregnant? **Yes/No**
Taking Oral Contraceptives? **Yes/No** Nursing? **Yes/No**

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

_____

Chief dental complaint:

_____

Is there anything you would like to change about your smile?

_____

Please add anything else you would like us to know about:

_____

By signing this I am certifying that I have answered these questions to the best of my ability.

Print Patient Name_____

Signature of patient (or guardian) _____ Date _____

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DENTAL INSURANCE INFORMATION

Name of Patient_____

Patient Date of Birth _____

Name of Policy Holder_____

Policy Holder Social Security Number_____

Policy Holder Date of Birth_____

Name of Employer_____

Name of Dental Insurance Co._____

Address of Dental Insurance Co. _____

Telephone of Insurance Co._____

Group Number_____

Contract Number_____

CONSENT FOR TREATMENT

I hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids he deems appropriate to make a thorough diagnosis of my dental needs. I authorize the doctor to perform any and all forms of treatment that may be indicated and to employ such assistance as he deems appropriate.

Signature of patient (or guardian) _____ Date _____

OUR FINANCIAL POLICY

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OVER THE MOUNTAIN
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Thank you for choosing Over the Mountain Dentistry as your dental provider. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions or concerns at any time, please let us know. Our staff is here to make your visit as pleasant as possible.

Payment. Full payment is due at the time of service. This is true for minor patients as well as adults. All services rendered to minor patients will be billed to the accompanying adult, parent or legal guardian. We accept cash, checks, Visa, MasterCard and Discover. **We charge $30.00 for any returned checks**.

Insurance & Costs. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. It is very important that you understand your policy provisions. We cannot guarantee your policy will pay all claims. If your insurer rejects a claim or pays only a portion of a bill, any contact or explanation should be made by you as the policyholder. The insurer's rejection or reduction of a claim **does not** relieve you of your financial obligation to OTM Dentistry. While we file insurance claims as a courtesy to our patients, all charges are your responsibility from the date that services are rendered, regardless of any insurance company's determination of usual and customary rates. In order for us to submit claims to your insurance company, you must provide us with your complete insurance information. We may or may not accept assignment of benefits.

Reservation fee. The practice may require a reservation fee for longer appointments.

Telephone Consumer Protection Act (TCPA)

You agree, in order for us to service your account or to collect monies you owe, Carter Mitchell, DMD and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/we have read this disclosure and agree that Carter Mitchell DMD, its employees and/or agents may contact me/us as described above.

Missed Appointments & Late Cancellations. Our goal is to provide quality dental care in a timely manner. We need your cooperation to achieve this goal. "No-Shows" and late cancellations inconvenience people who need prompt access to dental care. If it is necessary to cancel your scheduled appointment, **we require that you call 968.1296 at least 48 hours in advance** of your appointment so we have adequate time to fill the slot with another patient. **If you fail to comply with our cancellation policy, we will charge your account $80**.

Your signature indicates your understanding of our Financial Policy.

X_____ X _____
Print Patient Name Print Responsible Party Name

X_____ Date_____
Responsible Party Signature

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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

X_____X_____Date_____
Print Patient Name Print Responsible Party Name

X_____ Date_____
Responsible Party Signature

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NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

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- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 5.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Our Privacy Officer is **Carter Mitchell, DMD** * smiles@otmdentistry.com * 205.968.1296

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- Over the Mountain Dentistry follows Alabama law when it imposes greater requirements than federal privacy laws
- Over the Mountain Dentistry does not maintain psychotherapy notes
- Over the Mountain Dentistry does not market or sell patient information
- Over the Mountain Dentistry does not compile information for any hospital directory

Effective 2018

OVER THE MOUNTAIN
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CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize

Dr. Carter Mitchell DMD, 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*
- *Laboratory Communication*
- *Dental Research*
- *Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books*
- *Marketing material, including websites and printed materials, social media*

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

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

☐ Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient) _____

Date _____

2850 CAHABA ROAD, SUITE 140, MOUNTAIN BROOK, AL 35223
SMILES@OTMDENTISTRY.COM | 205.968.1296 | OTMDENTISTRY.COM