HOVEN & MORGAN

FAMILY & COSMETIC DENTISTRY

Welcome to Hoven & Morgan Family & Cosmetic Dentistry! Thank you for choosing our office for your dental needs. We appreciate the confidence and trust that you have placed in us and look forward to meeting you and developing a long-lasting relationship in your dental healthcare. Our staff is dedicated to providing the highest standard of quality in all dental procedures to ensure our patients' complete satisfaction. Using state-of-the-art dental technology, we help patients improve their smiles every day, and we want to do the same for you.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation, a dental cleaning and take any diagnostic x-rays that the dentist may recommend. This initial appointment will take approximately 90 minutes.

Enclosed you will find our NEW PATIENT REGISTRATION FORM, MEDICAL HISTORY QUESTIONNAIRE and DENTAL HISTORY QUESTIONNAIRE. Please fill these out completely and accurately and bring them with you to your first appointment, along with a list of any medications you are currently taking.

Again, we look forward to meeting you!

Sincerely,

Dr. Dane Hoven, Dr. Megan Morgan & Staff

HOVEN & MORGAN
FAMILY & COSMETIC DENTISTRY

Patient Registration

First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Email address: _____

We will text message or email your appointment reminders two days and two hours before your appointment.

Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Social Security #_____ Driver's License: _____
Emergency Contact: _____ Phone: _____

Responsible Party (if different from above):
First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Social Security_____Driver's License: _____

Primary Dental Benefits Provider:
Subscriber Name: _____
Employer Name: _____
Ins. Company: _____
Group ID: _____
Member ID: _____

Secondary Dental Benefits Provider:
Subscriber Name: _____
Employer Name: _____
Ins.Company: _____
Group ID: _____
Member ID: _____

In an effort to serve you better please answer the following question:
My spouse/significant other/best friend would consider me? (Please circle one).

Straight-to-the-point ☐ Social & Outgoing ☐ Steady & Dependable ☐ Cautious & Perfectly Accurate ☐

Notices:
Insurance is an aid to help in the payment of dental bills. All remaining balances are the responsibility of the patient.

In an effort to keep our dental fees as low as possible; a finance charge of 7.5% will be added to any delinquent accounts. Returned checks will be assessed a $50 processing fee, and all unpaid checks will be sent to the Bad Check Bureau at the Shelby County Attorney General's Office.

_____ _____
(SIGNATURE) (DATE)

HOVEN & MORGAN
FAMILY & COSMETIC DENTISTRY

DENTAL HISTORY

Name: _____ Birth Date: _____

Reason for Appointment: _____

Have you had regular preventive dental care in the past? ☐ YES ☐ NO

If yes: When & where was your last appointment? _____

Were x-rays taken? ☐ YES ☐ NO

Do you have any sore or sensitive teeth? ☐ YES ☐ NO

If yes: ☐ HOT ☐ COLD ☐ SWEETS

Do your gums bleed when brushing and flossing? ☐ YES ☐ NO

Are your gums red, swollen or tender? ☐ YES ☐ NO

Do you have any loose teeth? ☐ YES ☐ NO

Do you currently wear a denture or have a bridge? ☐ YES ☐ NO

Do you have any UN-COMPLETED treatment proposed by a previous dentist? ☐ YES ☐ NO

If yes, please explain: _____

_____

_____

Is it important to you that you keep all of your teeth? ☐ YES ☐ NO

Have you ever not scheduled dental treatment due to fear? ☐ YES ☐ NO

Have there ever been any injuries to your mouth? ☐ YES ☐ NO

Do you clench or grind your teeth? ☐ YES ☐ NO

Are you satisfied with the appearance of your smile? ☐ YES ☐ NO

What are some things you like about your smile? _____

If you could change anything about your smile, what would it be?

_____

_____

What are your general feelings towards coming to the dentist?

☐ I LOVE IT ☐ DOESN'T BOTHER ME ☐ A LITTLE NERVOUS ☐ VERY FEARFUL

_____ _____

(SIGNATURE) (DATE)

HOVEN & MORGAN
FAMILY & COSMETIC DENTISTRY

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
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 taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
						Yellow Jaundice	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

NOTICE OF HIPPA PRIVACY PRACTICES

Hoven & Morgan Family & Cosmetic Dentistry
7350 Cahaba Valley Rd, Ste106
205-533-6799

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we

do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Hoven and Morgan's Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

HOVEN & MORGAN
FAMILY & COSMETIC DENTISTRY

Financial Agreement

Thank you for choosing Hoven & Morgan Family & Cosmetic Dentistry for your dental care. We want to establish a long and pleasant relationship with you. Just as we are committed to providing excellent dental care, we also strive to make it affordable to you.

Please read, initial, and sign that you understand each of these policies.

_____ **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients. Dr. Hoven and Dr. Morgan do not have a contract with your insurance company, only you do. Our office is not responsible for how your insurance company handles its claims or for what benefits they pay. ***Most dental plans only cover a portion of the dental fee***, which means you will be responsible for your deductible and the estimated portion at the time services are rendered. We can only estimate your coverage in good faith. ***We at no time guarantee what your insurance will or will not cover***. As a service to our patients, we will bill your insurance company for services and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid in full. If you have any questions, please feel free to contact our office.

_____ A **DEPOSIT** is required in order to reserve appointment time for restorative work AND for all Saturday appointments.

_____ We gladly accept **Cash, Check, Visa, MC, and Discover**. Our office does not offer "in house" financing options, however, we have partnered with **Care Credit** (subject to credit approval). **Care Credit** offers several short term no-interest payment plans. You can apply for Care Credit in our office with the our assistance, over the phone at 1-800-365-8295 or online at www.carecredit.com

_____ **TREATMENT ESTIMATES** are presented to you on the day the treatment is proposed. Please remember that this is only an ***ESTIMATE.*** If you have any questions regarding treatment or the estimate given for services, you may contact our office at any time.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AGREE TO SUPPLY ALL NECESSARY INSURANCE INFORMATION TO HOVEN & MORGAN FAMILY & COSMETIC DENTISTRY .

_____ SIGNATURE

_____ DATE

HOVEN & MORGAN
FAMILY & COSMETIC DENTISTRY

Date: _____

Patient Name: _____
LAST FIRST

Please tell us how you learned about our practice. Please select **ALL** that apply:

- ☐ Friend/Family Name: _____
- ☐ Staff Member Name: _____
- ☐ Other Dentist/Doctor Name: _____
- ☐ Insurance Company Which Insurance? _____
- ☐ Internet Search
- ☐ Our Website
- ☐ Billboard
- ☐ Other: _____

HOVEN & MORGAN
FAMILY & COSMETIC DENTISTRY

APPOINTMENT AGREEMENT

Dr. Hoven and Dr. Morgan reserve an appointment time specific for you and your dental needs. We make every effort to value your time and stay on schedule, so we respectfully ask our patients to be prompt and keep their appointments. We are committed to your oral health and keeping your scheduled appointments allows us to be partners in your dental care. Our appointment policy is as follows:

COURTESY CONFIRMATION

We will attempt to contact you either by phone, text or email 48 hours prior to your scheduled appointment. This is to verify with you the day and time reserved for your dental needs.

48 HOURS NOTICE

If you must cancel or reschedule your appointment, please call our office at least 48 hours in advance. A 48 hour notice is required to cancel or change an appointment. A $50.00 fee may be charged to your account if the appointment is missed, cancelled or rescheduled without 48 hours notice. After 2 appointments in which the required 48 hours notice is not given, a $50.00 deposit may be required to schedule any further appointments with our office.

Exceptions to this policy will be determined only on an individual basis, according to the circumstances. We fully understand that unexpected emergencies can occur. Please contact our office immediately and we will do our best to accommodate your situation.

VIP APPOINTMENTS

Early morning, late afternoon and Saturday appointments are considered VIP appointments. **Saturday appointments require a $100.00 deposit in order to schedule.** If a VIP appointment is cancelled or rescheduled without 48 hours notice, the future VIP appointments cannot be scheduled.

***By signing this appointment agreement, you understand that your appointment time is a reservation with our office. Any appointment cancelled or rescheduled without 48 hours notice, may result in a $50.00 fee being applied to your account.

Signature _____ Date _____