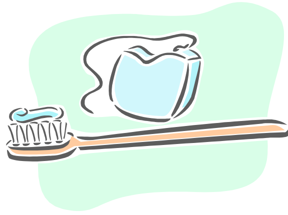


# Timothy E. Colby, D.D.S.

2704 W. 45th Street
Highland, IN 46322
219-924-2736


**Patient Number** ____________
(For office use only)

## Please Fill This Form Out Completely

Today's Date: _______________ Your email address: _________________________

Patient Name: First ____________________Last______________________________________

Marital Status: __________________________ Gender: _ Male _ Female

Street Address: ________________________________________________________

City: ______________________ State: _____________________Zip: ___________

Home Phone Number: _____________________Work Phone Number: ________________

Cell Phone: ___________________

Which number should we use to confirm appointments? ______________________________

Employer: ____________________________________________________________

Patient's Date of Birth: _________________________

Patient's Social Security Number: __________________________________________

Patient's Driver's License Number: __________________________________________

Whom may we thank for referring you? _______________________________________

Person to contact in case of Emergency: ______________________________________

Emergency Phone Number: _________________________________________________

Physician's Name: ____________________________ Phone: ____________________

## Responsible Party/Insured Party

Name: ________________________________________________________________

Relationship to patient: ___________________________________________________

Address: ______________________________________________________________

Phone: ________________________________________________________________

SSN: _____________________________DOB: _________________________________

Drivers License Number: ___________________________________________________

Employer: ______________________________ Work Phone: _____________________

Bank Name and Account Number ____________________________________________

**Your Medical History**

1. Are you currently taking any medication? If yes, please list below:

_______________________________________________

2. Do you have any allergies? (medications, latex, etc.)

If so, please list:_______________________________________________

3. Are you under medical treatment now? Yes___ No___
4. Have you been hospitalized for a surgical operation or serious illness within the last five (5) years? Yes___ No___

If yes, please explain_______________________________________________

_______________________________________________

5. Do you suffer from mental illness? Yes___ No___
6. Have you ever taken Phen-Fen/Redux? Yes___ No___
7. Do you use tobacco? Yes___ No___
8. Do you use controlled substances? Yes___ No___
9. Are you wearing contact lenses? Yes___ No___
10. Are you currently pregnant or nursing? Yes___ No___
11. Are you on birth control? Yes___ No___
12. Do you drink pop? Yes___ No___
13. Do you floss your teeth? Yes___ No___
14. Do you use mouthwash? Yes___ No___
15. Do you have or have you had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure: | Yes | No | Heart Disease: | Yes | No |
| Chest Pains: | Yes | No | Heart Attack: | Yes | No |
| Pacemaker: | Yes | No | Easily Winded: | Yes | No |
| Rheumatic Fever: | Yes | No | Heart Murmur: | Yes | No |
| Stroke: | Yes | No | Swollen Ankles: | Yes | No |
| Angina: | Yes | No | Hay Fever: | Yes | No |
| Fainting/Seizures: | Yes | No | Frequently Tired: | Yes | No |
| Tuberculosis: | Yes | No | Asthma: | Yes | No |
| Anemia: | Yes | No | Radiation: | Yes | No |
| Low Blood Pressure: | Yes | No | Emphysema: | Yes | No |
| Glaucoma: | Yes | No | Epilepsy: | Yes | No |
| Convulsions: | Yes | No | Cancer: | Yes | No |
| Weight Loss: | Yes | No | Leukemia: | Yes | No |
| Arthritis: | Yes | No | Liver Disease: | Yes | No |
| Kidney Disease | Yes | No | Diabetes: | Yes | No |
| Joint Replacement: | Yes | No | Heart Trouble: | Yes | No |
| AIDS/HIV infection: | Yes | No | Hepatitis: | Yes | No |
| Respiratory Trouble | Yes | No | Thyroid Trouble: | Yes | No |
| Muscular Dystrophy: | Yes | No | Mit. Valve Prolapse: | Yes | No |
| Stomach Trouble/Ulcers: | Yes | No | Sex. Trans. Disease: | Yes | No |

Other conditions: _______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any such treatment or examination rendered to me, or my child, during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_______________________________________
Signature of Patient (or parent, if minor)

## Responsible Party Please read and sign below:

I understand that a $40 fee may be charged to my account if I break my appointment and fail to give 24 hour notice to Dr. Colby. This fee will be due and payable prior to scheduling any subsequent appointments. If there are any charges for dental services and materials, I will pay these charges within thirty (30) days of services rendered. If my bill is unpaid for more than thirty (30) days, I will pay a $25.00 late fee per month. I will also pay a monthly finance charge of the greater of five dollars ($5.00) or one and a half (1 _ %) percent of the unpaid balance, and costs of collection, including any attorney fees and court costs.

______________________________________________________________________________
Signature of patient or responsible party Date

If unable to speak directly to the responsible party, I allow Colby Dental to speak with my spouse/domestic partner as related to account balance.

______________________________________________________________________________
Signature of patient or responsible party Date

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at each appointment. Thank you!

_______Cash _______Check _______Credit Card

Note: If you choose to pay by check, your Driver's License Number is required on each check.

**Please let us know if your insurance information has changed. Thank you!**

Colby Dental
2704 W. 45th Street
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(219) 924-2736

# Notice of Dental Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purpose: treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care provides. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identifies by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we much abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of 4-14-2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Timothy Colby, D.D.S
2704 W. 45th Street
Highland, IN 46322
Telephone (219) 924-2736

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
Toll Free: 1-877-696-6775

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* form time to time and that I may contact this organization at any time at the address about to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____________________________________________

Relationship to Patient ______________________________________

Signature: _______________________________________________

Date: _____________________________________________

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Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date:________ Initials:_____ Reason_______________________________