WELCOME

We are happy to welcome you to the office of Dr. Robert Durbin, Dr. Derek Durbin, Dr. Kelley Hathaway, and Dr. Amy Leiker.

Our office is located on 37th street, just past the corner of 37th and Fairlawn Rd.

We strive to make each visit in our office as pleasant as possible. Our office offers services for the family. We perform preventative services, as well as, composite fillings, crowns, bridges, veneers, and root canals. We also offer conscious oral sedation and IV sedation.

We are providers for a large number of insurance companies and we will file your insurance for you. However, it is your responsibility to know the contents of your dental policy. We do expect to receive your share of payment at the time of service. While we do not take payments, we do accept Visa, MasterCard, Discover, and American Express in addition to checks and cash. Another option we offer is the Care Credit card. After filling out an application, we apply on line for you, and if you are accepted by Care Credit, they will allow you to make payments for up to twelve months with no interest.

If you have any questions regarding our services, please telephone our office staff.

Today's Dentistry, LLC

Derek C. Durbin D.D.S.
Robert H. Durbin, D.D.S.
Kelley A. Hathaway D.D.S.
Amy M. Leiker D.D.S.
5310 SW 37th Street
Topeka, KS 66614
785-267-5010
office@durbindds.com

Date_____ Date of birth_____

Patient Name: _____
Last First Middle Initial

Residence: _____
Number & Street City State Zip

Telephone: Home_____ Business_____

Cell_____ Email Address_____

SS#_____ Employer and Position: _____

Marital Status_____ Spouse's Name: _____

Date of Birth_____ Spouse's Employer: _____

Spouse's Social Security #_____

Primary Insurance_____ Employer_____
(if different from above)

Name of Insured and Address _____
(if different from above)

Phone #_____ Date of birth_____
(if different from above)

Insurance ID or SS#_____ Relationship to patient_____

Secondary Insurance_____ Employer_____
(if different from above)

Name of Insured and Address _____
(if different from above)

Phone #_____ Date of birth_____
(if different from above)

Insurance ID or SS#_____ Relationship to patient_____

Whom may we thank for referring you? _____

In the event of an emergency who should we contact_____

Relationship to patient_____ Telephone#_____

The parent or guardian completing this information will be assumed to be the responsible party, and will be billed accordingly. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payments of benefits. **I understand that I am financially responsible for all charges whether or not paid by insurance. If this form is not filled out in its entirety, your insurance may not be able to be filed, and you will be responsible for filing yourself.**

_____
Signature Date

Medical History

Patient Name _____ Date of Birth _____

Are you under a physician's care now? Y N If yes, please explain _____
Have you ever had a major operation? Y N If yes, please explain _____
Have you ever had a serious head or neck injury? Y N If yes, please explain _____
Are taking any medications, pills, or drugs? Y N If yes, please explain _____
Do you take, or have taken Phen-Fen or Redux? Y N _____
Are you on a special diet? Y N _____
Do you use tobacco? Y N
Do you use controlled substances? Y N

Women: Are you: (please circle)
Pregnant? Trying to get pregnant? Taking oral contraceptive? Nursing?

Are you allergic to any of the following? (Please circle if you are allergic)
Aspirin Penicillin Codeine Sulfa Acrylic Metal **Latex**

Local Anesthetics Others not listed, please explain _____

Circle if you have, or have ever had, any of the following:

AIDS/HIV positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pain
Cold Sores
Congenital Heart Disorder
Convulsions
Cortisone Meds
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/ Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headache
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/ Disease
Hemophilia
Hepatitis A, B, C
Herpes
High Blood Pressure
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Pain In Jaw Joint
Parathyroid Disease
Psychiatric Care
Radiation Treatment
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatic Fever
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain_____

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Date of last dental care? _____ Date of last x-rays? _____

Please circle if you are having any of the following.

Bad breath
Bleeding Gums
Clicking of popping jaw
Food collection between teeth
Grinding or clenching
Loose teeth or broken fillings
Periodontal treatment
Sensitivity to cold
Sensitivity to hot
Sensitivity to sweet
Sensitivity when biting
Sores or growths in mouth

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 or guardian _____ Date _____

NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") 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. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", 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 purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement of 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 practice, 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 alternative 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 right 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 identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must 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.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure to protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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 May, 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 the 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 & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Today's Dentistry
5310 SW 37th Street
Topeka, KS 66614

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain right 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 operation such as quality assessments and physicians certifications.

I acknowledge that I have received 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* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments 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 _____