TOPPING DENTAL GROUP

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Nappanee, IN 46550
574-773-9700

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Middlebury, IN 46540
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574-848-7487

Patient Information

Referred By: ☐ Name of Friend/Relative__________ ☐ Newspaper ☐ Radio ☐ Television ☐ Outside sign ☐ Walk-in ☐ Homes Direct ☐ Phone Book

(If Responsible Party is same as Patient-write SAME)

Responsible Party___________________________ Date of Birth____/____/______S.S.#_____-____-_______
Address___________________________City___________________ State_____Zip______________________
Telephone ______________Cellular #____________________Work # __________________________________
Place of Employment_______________________________City_____________Zip________________________
Spouses Name:_____________________________

*****TREATMENT PLAN PRICES ARE GUARANTEED UP TO 30 DAYS FROM DIAGNOSIS DATE.***

PRIMARY INSURANCE:
Insurance Subscriber Information: (**please present insurance card and photo I.D. for photocopy**)
Insurance Carrier _________________________________
Subscriber Name___________________________ Date of Birth_____/____/_____S.S.#_____-____-_______
Group Number____________________________________Subscriber ID _______________________________
Telephone______________Cellular#____________________Work#___________________________________
Place of Employment_______________________________City_____________Zip______________________
Insurance telephone # _______________________________

***In Indiana, both parents are equally responsible for minor children. A divorce decree/support order is between those two parties – *NOT THE PROVIDER*!**

*Non-duplication clause? We have recently noticed that many insurance carriers are imposing a non-duplication of benefits (carve out) "clause" for coordination of benefits on some employer group contracts. So, if the insurance carrier is the secondary carrier, the claim payment is determined as follows: "Payment is determined by deducting the primary carrier's payment from the procedure and then paying the additional amount after adjusting out the amount the primary paid. Usually, this results in no additional payment or a small amount of benefits paid out based on the contract fee schedule. Patients with dual coverage will often think that they have 100% coverage. Unfortunately, this is not the case with non-duplication clauses.
_______**initial (if filing secondary insurance)**

***$50.00 NO SHOW/MISSED APPOINTMENT FEE will be added to your account if we do not receive a 2 business day notification for rescheduling appointments.

Topping Dental Group

Patient Information

We will as a courtesy to our patients, file a claim with your insurance carrier. If you wish us to file, you will have to provide us with the subscribers date of birth, social security number, group number and name and address of where the claim is to be sent. By signing this form you are also authorizing payment of dental benefits to be paid to Dr. Brian R. Topping. You also understand that it is your responsibility to know exactly what your insurance plan will pay for in regards to any and all treatment. You also accept responsibilities for fees that exceed the payment amount made by your insurance company, if the Practice does not participate with your insurance company. You certify that the information on this sheet is true and correct to the best of your knowledge. You will also notify this office of any changes in status of the above information. However, responsibility for full payment of this account is yours. You, the patient or responsible parties of a minor, will be responsible for any costs incurred to collect any unpaid debt, including, but not limited to, Collection Fees, Interest Fees, and Attorney Fees. By signing this form you also agree to pay all co-payment, coinsurance, and deductibles or if not filing any insurance, payment in full, at the time all services are rendered.

FINANCIAL AGREEMENT The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to a collection agency or an attorney for collections, the undersigned will be required to pay reasonable attorney's fees and collection fees. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. ________ (initials)

➢ ____ ____________________

Signature of Patient or Guardian **Date**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ______________________, hereby authorize Dr. Brian R. Topping to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this content is voluntary, if I refuse to sign this consent, Dr. Brian R. Topping can refuse to treat me.

I have been informed that Dr. Brian R. Topping has prepared a ("Notice") which more fully describes the uses and disclosures that can be made of my individual identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Dr. Brian R. Topping, in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Brian R. Topping took before receiving revocation.

I understand that Dr. Brian R. Topping has reserved the right to change his privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Brian R. Topping restricts how my individual identifiable health information is used and/or disclosed to carry out treatment, payment or health operations.

I understand that Dr. Brian R. Topping does not have to agree to such restrictions, but that once such restrictions are agreed to, Dr. Brian R. Topping must adhere to such restrictions.

By signing below, I understand and have received the "Notice of Privacy Practices" and I give my consent for use and disclosure of any of my health information.

➢ ____________________________ _________________________ _________________

Signature of Patient or Guardian **Printed Name** **Date**

➢ **You will <u>automatically</u> be enrolled in email and text reminders. If you would like to <u>OPT OUT</u> please check the appropriate box:**

☐ OPT OUT OF TEXT ☐ OPT OUT OF EMAIL ☐ OPT OUT OF BOTH

ADA American Dental Association®
America's leading advocate for oral health

Today's Date: ______________________________

Child's Dental & Medical Health History Information

To the parents/guardians of the patient: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? ______________________

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? ____________ What was done at that appointment? ______________________

When was the last time the patient had dental x-rays taken?

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**	**?**
Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: ______________________	☐	☐	☐
Has the patient had any problems with teeth coming in or losing teeth?	☐	☐	☐
Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? ______ time(s) per _______ At what time(s) of day are the teeth brushed? __________	☐	☐	☐
Has the patient ever worn braces or other orthodontic appliances?	☐	☐	☐
Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: ______________________	☐	☐	☐
Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: ______________________	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well			
Does the patient take fluoride supplements?	☐	☐	☐
Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? __________ At what age did the patient stop bottle feeding? __________	☐	☐	☐
Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep			

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PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

Please list the name and phone number of the patient's physician:

Doctor's Name: ______________________________ Phone: ______________________

Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. ______________________________

Please use an "X" to mark your answers to the following questions.	Yes	No	?	
Is the patient currently being treated for any condition(s) or illness(es)?	☐	☐	☐	If yes, what is the illness and when did it start?
Has the patient ever had a serious illness?	☐	☐	☐	If yes, what was the illness and when did it happen?
Has the patient ever been hospitalized?	☐	☐	☐	When and why?
Has the patient ever been given a general anesthetic?	☐	☐	☐	
Has the patient ever had a blood transfusion?	☐	☐	☐	
Does the patient experience excessive bleeding when cut?	☐	☐	☐	
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist?	☐	☐	☐	If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: ________________ Phone: __________
Has the patient been diagnosed with any physical, developmental, mental or emotional conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any genetic (inherited) conditions?	☐	☐	☐	If yes, please explain.
Does the patient have any speech difficulties?	☐	☐	☐	If yes, please explain.

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to patienthood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

- ☐ ADD/ADHD
- ☐ Alcohol/Drugs
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Bleeding disorders
- ☐ Bone/Joint issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic sinusitis
- ☐ Diabetes
- ☐ Ear aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth problems
- ☐ Hearing problems
- ☐ Heart Issue
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Immunizations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually transmitted infection (STI)
- ☐ Sickle Cell Anemia
- ☐ Thyroid issues
- ☐ Tobacco/Vaping
- ☐ Tuberculosis
- ☐ Other: ______________________

  ____

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications? If yes, please list them here: ______________________________	☐	☐	☐
Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications? If yes, please list those medications and what happened when the patient took them: ______________________________	☐	☐	☐
Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.? If yes, please describe the allergy and the reaction: ______________________________	☐	☐	☐

NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: ______________________________ Date: ______________________

FOR COMPLETION BY DENTIST

Comments: ______________________________

Office Use Only:

☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: ______________________________ Date: ______________________

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Brian R. Topping, DDS, FICOI, PC * Jeffrey A. Swihart, DDS
Phillip A. Jakubowicz, DDS
Topping Dental Group

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

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 law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.
For Example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar form of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

***Required by Law*:** We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for copy expenses. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure or 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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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.

Contact Officer: Stephanie Topping

Telephone: (574) 773-9700
Fax: (574) 773-9709
E-Mail: N/A
Address: 102 W. Market St.
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