# Julia Tyson Snyder D.D.S, P.A

450 New Market Blvd, Suite #2, Boone, NC 28607
Phone: (828) 265-1112 Fax: (828) 265-2836
Email: mindycda@gmail.com

## PATIENT INFORMATION

Patient's Name: ______________________________ Sex: M F Birthdate: ____________ Age: _______

SS# ______________ Today's Date: ____________ If patient is a minor, give parent's or guardian's name: ____________________

Mailing Address: ______________________________________________

Email Address: ________________________Whom may we thank for referring you to our office? ____________________

Phone: Home ____________________ Cell ____________________ Work ____________________ Ext: _________

Employer/student ______________________________________________

## RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Name: ________________________ Mailing Address: ________________________

Best Contact Phone Number: ________________________ Relationship to Patient: ________________________

## EMERGENCY INFO

Name: ______________________________

Address: ______________________________

City, State: ______________Relationship: ______________

Home: ______________ Cell Phone: ______________

Work Phone: ____________________ Ext: ___________

## DENTAL INSURANCE INFORMATION

Policy Holder's Name: ______________ Employer: ______________

Birthdate: ______________ SS#: ______________

Insurance Company: ______________________________

Address: ______________________________

Group #: ______________ Policy #: ______________

## ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES

I understand that for my convenience Dr. Tyson Snyder accepts Cash, Checks, Visa, MasterCard, Discover or Care Credit. I also understand that with my Dental Insurance, Dr. Tyson Snyder files it as a courtesy and none covered amounts and deductibles are due at the time the services are rendered. If for any reason my insurance company does not pay its estimated portion, the balance will be my responsibility. A fee may be charged for patients who miss or cancel without 24-hour notice. A copy of Driver's License/Photo ID is required for every patient.

I have read and understand the Financial Policy and Notice of Privacy Practices for the above named practice.

______________________________________ ______________________

Signature of patient or legal guardian Date

# Medical History

| | Yes | No |
|---|---|---|
| **1.** Do you have current health problems? | ☐ | ☐ |
| **2.** Have you been hospitalized in the last 2 years? If yes, for what? ________________________ | ☐ | ☐ |
| **3.** Are you under physician's care now? If yes, for what? ________________________ | ☐ | ☐ |
| **4.** Has a physician **(Medical Doctor)** recommended Taking antibiotics prior to every dental visit **(premed)**? (Example: joint replacement or heart conditions) | ☐ | ☐ |
| **5.** Women: Is there a possibility of pregnancy? | ☐ | ☐ |
| **Expected delivery date** ________________ **Are you nursing?** | ☐ | ☐ |
| **Are you taking Birth Control pills? (Antibiotics may alter the effectiveness.)** | ☐ | ☐ |
| **6.** Have you ever taken Bisphosphonates(Fosamax Phen-fen or redux? | ☐ | ☐ |

**7.** What medications are you currently taking?

____________________________________

____________________________________

| | Yes | No |
|---|---|---|
| **8.** Are you allergic to or have you reacted adversely to any of the following medications? | ☐ | ☐ |

- ☐ Ibuprofen
- ☐ Codeine
- ☐ Clindamycin
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Latex (balloons, gloves, etc.)
- ☐ Household Bleach
- ☐ Sulfa Drugs
- ☐ Aspirin
- ☐ Acrylic
- ☐ Metal
- ☐ Local Anesthetics

| | Yes | No |
|---|---|---|
| **9.** Are you aware of being allergic to any other medication or substances? If yes, please list _______________________________________ | ☐ | ☐ |
| **10.** Do you use controlled substances? | ☐ | ☐ |

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

| Yes | Yes |
|---|---|
| ☐AIDS/ HIV positive | ☐Hypoglycemia |
| ☐Alzheimer's Disease | ☐Irregular heartbeat |
| ☐Anaphylaxis | ☐Jaw pain |
| ☐Anemia | ☐High blood pressure |
| ☐Angina | ☐Kidney disease/malfunction |
| ☐Anxiety | ☐Liver disease |
| ☐Arthritis/Gout (Rheumatoidism) | ☐Low Blood Pressure |
| ☐Artificial heart valves | ☐Mitral valve prolapse |
| ☐Artificial joints | ☐Central nervous problems |
| ☐Asthma | ☐Osteoporosis |
| ☐Back/neck problems | ☐Pacemaker/heart surgery |
| ☐Blood disease | ☐Psychiatric care |
| ☐Cancer | ☐Rapid weight gain/loss |
| ☐Chemical dependency | ☐Radiation treatment |
| ☐Chemotherapy | ☐Respiratory disease |
| ☐Circulatory problems | ☐Rheumatic/Scarlet fever |
| ☐Steroid treatments | ☐Shingles |
| ☐Cough up blood | ☐Shortness of breath |
| ☐Diabetes | ☐Sinusitis/Sinus Trouble |
| ☐Epilepsy | ☐Stroke |
| ☐Fainting | ☐Swelling of feet or ankles |
| ☐Glaucoma | ☐Thyroid disease/malfunction |
| ☐Headaches | ☐Tobacco habit |
| ☐Hemophilia (abnormal bleeding) | ☐Tonsillitis |
| ☐Genital Herpes or Herpes | ☐Tuberculosis |
| ☐Hepatitis A, B, or C | ☐Ulcer/Colitis |

☐Heart Problems (please describe)________________________________

## Consent Statement

I affirm that the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Tyson Snyder or any office member responsible for problems arising from errors or omissions that I made in the completion of this form. I consent to any advisable and necessary dental treatment to be administered by Dr. Tyson Snyder and staff for diagnostic purposes or dental treatment. I understand that the consequences of doing nothing that is recommended by Dr. Tyson Snyder and staff might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of teeth, and/or other systemic disease problems.

**PLEASE INITIAL**____________

If you have any questions, please do not hesitate to ask. We are here to help you.

SIGNATURE__________________________________________________ Date______________________

WITNESS____________________________________________________ Date______________________

## Your Rights Continued

Public health: We May disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive information. The disclosure will be made for the purpose of controlling disease, injury or disability. Additionally, we may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease condition.
We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Abuse and Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose you protected health information if we believe that you have been a victim of abuse, neglect or domestic violence of the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
Military Activity and National Security: When the appropriate conditions apply, we may disclose, to military authorities, protected health information of individuals who are Armed Forces personnel. We may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services of the President or others legally authorized.
You have the right to receive an accounting of certain disclosures we have made, If any, of your protected health information. This right applies to disclosures made by our Business Associates or us. It excludes disclosures for treatment, payment or healthcare operations as described in this Notice of Privacy Practices, to you, to family members or friends involved in your care, for notification purposes or as a result of an authorization signed by you. You have the right to receive specific information regarding these disclosures that occurs after April 12, 2003 for up to the previous 6 years. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. If you request accounting information more than once in a 12 month period, we will charge you a reasonable cost based fee for responding to the additional request.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

## Questions and Complaints

If you have any questions concerns or want more information about our privacy practices please contact us using the information below

If you are concerned that we may have violated your privacy rights or you disagree with a decision we have made regarding your access to your health information or any other request you have made in the exercise of your rights, you may send your complaint to us using the information below. You may also submit a written complaint to the Secretary of Health and Human Services. Contact us for the address of the Department of Health and Human Services.

We support your right to the privacy of your health information and we will not retaliate against you in any way for filing a complaint.


**Julia Tyson Snyder D.D.S, P.A.**

**450 New Market Blvd**
**Suite 2**
**Boone, NC 28607**
**Phone: 828-265-1112**
**Fax: 828-265-2836**
**Email: mindycda@gmail.com**
**www.juliatysondds.com**

# Julia Tyson Snyder D.D.S, P.A

## 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.

This notice describes how we may use and disclose your protected health information to provide treatment, obtain payment and conduct health care operations and for other purposes permitted or required law. It also describes your rights concerning your protected health information. "Protected health information" is the information about you and relates to you past, present and future physical or mental health or condition and related health services.

We are required by law to follow the practices described in this Notice. We may change the terms in this notice at any time. The new Notice will be effective for all protected health information we created or received before we made the changes.

You may obtain a copy of our Notice of Privacy Practices at any time by calling our office or requesting one at your next appointment.

# Uses and Disclosures of Health Information

Treatment: We will use and disclose your health information to provide, coordinate and manage health care and related services for you. For example we will disclose information to a specialist to whom you have been referred to ensure the provider has enough information to diagnose and/or treat you. We may also disclose information to a laboratory that, at our request, becomes involved in your treatment.

Payment: We may use and disclose your information to obtain payment for services we provided to you. For example we will send the necessary information to your health or dental insurance company to obtain payment for the treatment provided.

Healthcare Operations: We will use and disclose your health information to conduct the business activities of this office. These activities include, but are not limited to, quality assessment and improvement activities, review of the performance and qualifications of employees, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign you name. We may also call you by name in the waiting room when we are ready to begin your treatment.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Others involved in your health care: 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 or other person to the extent necessary to help with your health care with payment for your health care, but only if you agree. If we determine it is in your best interest based on our professional judgment or experience with common practices, we may allow another person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information.

We may use or disclose protected health information to notify or assist in notifying a family member, a personal representative or any other person responsible for your care of your location of you, your general condition or death. If you are present prior to the use or disclosure of your protected health information, we will provide you with the opportunity to object to such uses or disclosures. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinated uses and disclosures to family members or others involved in your health care.

Emergencies: In the event of your incapacity or in emergency circumstances, we may use or disclose your protected health information to treat you.

Uses and Disclosure of Protected health Information based upon Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already been taken reliance on the authorization.

Other Permitted and Required Uses and Disclosures That May be Made Without Your Consent, Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or Authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Worker's Compensation: We may disclose your protected health information as authorized to comply with workers compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

## Your Rights

Your Rights with respect to your protected health information and how you may exercise those rights are outlined here.

You have a right to obtain a copy and/or inspect your health information: health information includes treatment records, billing records and any other records used by us to make a decision about your treatment. You may obtain a form from our office to request access. A reasonable cost based fee will be charged for expenses such as staff time, copies and postage. Contact us as indicated at the end of the notice to obtain information about our fees or if you have any questions about your access.

You have a right to request a restriction on the use and disclosure of your protected health information: You may ask us not to use or disclose some part of your protected health information for the purposes of treatment, payment or operations. You may also request that we not disclose some part of your information to family and others who may be involved in your care or for notification purposes as otherwise described in this notice. We are not required to agree to the restrictions but if we do, we are obligated to abide by the agreement except in cases of emergency. You may request a restriction by sending your request in writing to our office.

You have a right to request to receive confidential communications by alternative means or at an alternative location: We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address of other method of contact. We will not request and explanation from you as to the basis for the request. Please make this request in writing to our office.

You have the right to request an amendment to you protected health information: You may request that we amend protected health information about you. Your request must be in writing with an explanation as to why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
We must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule, Section 164.500 et. Seq.

# JULIA TYSON SNYDER DDS, PA

**FINANCIAL POLICY**

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED; WE ACCEPT CASH, CHECK (PROCESSED ELECTRONICALLY), VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER DEBIT AND CREDIT CARDS.**

**PAYMENT PLANS:**

We have payment plans through care Credit. Care Credit must be approved before appointment is scheduled. We offer the 12 month interest free payment plans.

**USUAL AND CUSTOMARY FEES:**

Our fees are what are usual and customary in our area and designated by our preferred insurance community, not what your insurance company feels are usual and customary. You are responsible for any fees that are above your insurance company's usual and customary fees unless we have a contract fee with your insurance company or are a participating preferred provider (PPO) for your insurance company.

**CONFIRMATION:**

You are responsible for keeping your scheduled appointments. Starting two (2) DAYS before your appointment, we will attempt to contact you as a courtesy by phone to confirm your appointment. A prompt response to confirm your appointment is required to secure your appointment 24 hours prior to your scheduled appointment. If we cannot reach you by phone, it is your responsibility to contact us to secure your appointment. Failure to confirm your appointment may result in the cancellation and a "failed appointment status" of your appointment.

**BROKEN APPOINTMENT POLICY:**

We kindly ask that you give us at least 24 hours advance notice if you cannot make it to your appointment. Failure to do this may result in a charge of $75 per hour missed. Failure to attend an additional appointment may lead to your dismissal from our practice. Understand that we are implementing this policy for the improvement and flow of our office.

**OFFICE FEES:**

All major procedures will be collected before services are rendered.

**PATIENT RESPONSIBILITY REGARDING INSURANCE USAGE**

1. You must provide us with a copy of your dental insurance card. If you have any changes in your insurance information you are responsible for giving us the correct information before your appointment. Failure to do so will result in paying out of pocket for the visit.

2. We will attempt to verify that you have coverage with this insurance. If we cannot verify your insurance, you will need to pay for your visit in full and we will provide you with a copy of services rendered to file your claim. If your insurance requires a social security number to verify benefits you must provide it to us or we will not file your insurance.

3. We only verify your insurance coverage and basic breakdown of your benefits. You are responsible for knowing what services your insurance company does and does not cover and when services were last rendered to you.

4. Insurance companies do not guarantee us payments, so any fees stated to you are estimates only.

5. Services are rendered to you, not your insurance company. We will not be involved with any disputes you have with your insurance company.

6. You may have your services pre-authorized by your insurance company. This will tell us an estimate of what your insurance company will pay for services and what your portion of the services will be. Insurance never gives a guarantee of payment.

7. It is your responsibility to call your insurance company to find out why they have not paid your claim.

8. You are responsible for any monies that your insurance does not cover. IE: Alternate benefits, denied claims due to missing tooth clauses, frequency of services, age limitations, deductibles, plan limitations. Etc.

9. You are responsible for paying all deductibles and co-payments at the time of service.

10. It is your responsibility to pay any amount over what your insurance company's reasonable and customary fees are.

**I HAVE READ, UNDERSTAND AND AGREE TO THE STATEMENT OUTLINED ABOVE.**

Patient Printed Name:______________________________________ Date: ______________________________

______________________________________________________

Patient or Guardian Signature

# JULIA TYSON SNYDER DENTISTRY INFORMED CONSENT

I hereby authorize my dentist, Dr. Julia Tyson Snyder, DDS and whoever she may designate as her assistants and/or hygienists to perform upon me those dental procedures which, upon discussion, I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize upon discussion what he/she deems advisable.
I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and re-infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of teeth and gums during and following dental cleanings.
The most common of these complications in oral surgery include post-operative bleeding, swelling or bruising, discomfort stiff jaws, and loss or loosening of dental restorations. Other less common complications include, but are not limited to: infection, loss or injury to adjacent teeth and soft tissues, jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations, nerve disturbances (e.g. numbness in mouth and lip tissues), and small root fragments remaining in the jaw which might require extensive surgery for removal. These complications may be temporary or permanent.
I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes, but is not limited to, the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections or any medications or drugs.
A more complete explanation of all complications is available to me upon request from the DOCTOR.
I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Patient Printed Name:______________________________________________________ Date________________________

Patient or Guardian Signature: ________________________________________________

# Authorization for Release of Information

Name of Patient ___________________________________ Date of Birth ________________

**JULIA TYSON SNYDER, DDS, PA is** authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others with the patient's health information.

| **Entity to Receive Information.** Check each person/entity that you approve to receive information. | **Description of information to be released.** Check each that can be given to person/entity on the left in the same section. |
|---|---|
| ❑ Voice Mail | ❑ Results of lab tests/x-rays<br>❑ Other________________________________ |
| ❑ Spouse (provide name) | ❑ Financial<br>❑ Medical as follows:_____________________<br>_____________________________________ |
| ❑ Parent (provide name)<br>_____________________________________ | ❑ Financial<br>❑ Medical as follows:______________________<br>_______________________________________ |
| ❑ Other (provide name) __________________<br>____________________________________ | ❑ Financial<br>❑ Medical as follows ______________________<br>_______________________________________ |

**Patient Information**
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.* This authorization shall be in effect until revoked by the patient.

__________________________________________________________Date_______________
Signature of Patient or Personal Representative
Description of Personal Representative's Authority (attach necessary documentation)

## Acknowledgement of Receipt
## Of Notice of Privacy Practices

Patient Name & Address: ______________________________________________________

I have received a copy of the Notice of Privacy Practices for the above named practice.

____________________________________________ ________________________

Signature Date

## For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason: ______________________________________________
- ❑ Other:______________________________________________

Prepared By ____________________________________

Signature ____________________________________

Date ____________________________________