New Patient Information

Patient Name _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security _____ Birth Date: _____

Phone (Home) _____ (Work) _____ (Cell) _____ (Other) _____

Address: _____ Email: _____

City State Zip Code

Referral Information

How did you hear about us or whom may we thank for referring you to our practice? _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

_____
Street City State Zip Code

Student Information

If you are a student, please list: **School Name:** _____ **Enrollment Status:** _____

Your school contact information: _____

If you are 18 or older, or signing consent for a minor, you are the responsible party.

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell) _____

Address: _____
Street Apartment #

_____
City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Although dental personnel primarily treat the area in around your mouth, your mouth is 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.

- Current Physician _____ City _____ State _____ Phone _____
- Preferred Pharmacy: _____ Location _____ Phone _____
- Are you now under the care of a physician? ☐ Yes ☐ No Doctor's Name _____
  If yes, please explain: _____
- Do you have any/pins/plates/artificial joints? ☐ Yes ☐ No Surgeon's Name _____
  If yes, please explain: _____
- Do you use tobacco in any form? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications, pills, or drugs? ☐ Yes ☐ No Blood Thinner? ☐ Yes ☐ No
  If yes, please explain: _____
- Ladies: Are you pregnant or nursing? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No
- Have you ever taken Boniva, Reclast, Fosamax, Aredia, Prolia, Zometa or any Bone Density medications? ☐ Yes ☐ No

PLEASE MARK ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH HISTORY

☐ Pre-Med_____
☐ Allergy-Codeine
☐ Allergy-Penicillin
☐ Anemia
☐ Artificial Joints
☐ Bruise Easily
☐ Cortisone Medicine
☐ Epilepsy/Seizures
☐ Frequent Cough
☐ Head Injury
☐ Hemophilia
☐ Hypoglycemia
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Psychiatric Care
☐ Sinus/Hay Fever
☐ Tuberculosis

☐ Allergy - Aspirin
☐ Allergy - Erythromycin
☐ Allergy - Sulfa
☐ Angina/Chest Pain
☐ Asthma
☐ Cancer
☐ Diabetes
☐ Excessive Bleeding
☐ Frequent Headaches
☐ Heart Murmur
☐ Hepatitis A
☐ Irregular Heart Beat
☐ Pain in Jaw Joints
☐ Radiation/Chemo Tx
☐ Stomach Problems
☐ Tumors

☐ Allergy - Keflex
☐ Allergy-Anesthetics
☐ Art Heart Valve
☐ Blood Disease
☐ Cold Sore/Fever Blister
☐ Drug Addiction
☐ Excessive Thirst
☐ Glaucoma
☐ Heart Pacemaker
☐ Hepatitis B or C
☐ Kidney Prob/Disease
☐ Pins/Plates
☐ Respiratory Problems
☐ Stroke
☐ Thyroid Issues
☐ High Cholesterol

☐ Allergy - Latex
☐ Alzheimer's Disease
☐ Arthritis/Gout
☐ Blood Transfusion
☐ Cong Heart Disorder
☐ Emphysema/COPD
☐ Fainting/Dizziness
☐ H/L Blood Pressure
☐ Heart Trouble /Disease
☐ HIV/AIDS
☐ Liver Disease
☐ Pregnancy
☐ Rheumatic Fever
☐ Taking BCP

Please list any other **MEDICAL CONDITIONS** that are not listed above:

_____

Please list any other **DRUGS or MEDICATIONS** that you are **ALLERGIC** to that is not listed above:

_____

- Previous Dentist: _____ City: _____ Phone: _____
- Approximate date of last dental cleaning and full mouth x-rays _____
- How often to you brush your teeth? _____ How often do you floss? _____
- Are you have dental discomfort currently? ☐ Yes ☐ No
- Does Food catch between your teeth? ☐ Yes ☐ No
- Do your gums bleed when brushing your teeth? ☐ Yes ☐ No
- Do you have a problem with bad breath? ☐ Yes ☐ No
- Do you clench your teeth during the day or night? ☐ Yes ☐ No
- Do you have pain in or near your ear? ☐ Yes ☐ No
- Do you have popping/clicking in your jaws? ☐ Yes ☐ No
- Do you have any growths or mouth sores? ☐ Yes ☐ No
- Do you have any current or future interest in orthodontics (braces)? ☐ Yes ☐ No
- Have you ever seen a periodontist, had gum treatments or surgery? If yes, please list name of Doctor:

_____

- Have you or your family ever seen an oral surgeon/endodontist (root canal) another specialist? If yes, list name of Doctor:

_____

- Have you had difficult extractions in the past? If yes, please explain: _____

I certify that I have read the information above. To the best of my knowledge, the questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature _____ Date _____

CONSENT FOR CARE & TREATMENT

I, the undersigned, do herby agree and give my consent for UNIVERSITY GENERAL DENTISTRY to furnish dental care to

(PRINT NAME) _____ considered necessary & proper in diagnosing or treating his/her dental condition.

Patient/Guardian/Responsible Party **(SIGN NAME)** _____ **Date** _____

BENEFIT ASSIGMENT/RELEASE OF INFORMATION

I hereby assign all dental and/or medical benefits to include major medical benefits to which I am entitled, including private insurance and third-party payors to UNIVERISTY GENERAL DENTISTRY. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian/Responsible Party **(SIGN NAME** _____**)** **Date** _____

FINANCIAL POLICY STATEMENT

We bill your insurance solely as a courtesy to you. Even though we may try to give estimates of your insurance benefits, this is done solely as an ESTIMATE and we cannot be held responsible for what your insurance ultimately chooses to pay or not to pay. Estimated coverage information is provided as a courtesy to you, but is not intended to release you from your responsibility for your account balance. It is up to you to be aware of your insurance benefits. Any disputes between you and your insurance company are your responsibility to resolve. You are responsible for your bill at time of service fee less than $150.00. We accept cash checks and some bank cards. Some financial arrangements may be made for fees more than $150.00 but all copays and deductibles are due at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due from you in full and any further filings at this point become your responsibility. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. There is a $2.00 per month rebilling fee on accounts over 90 days old.

If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same to UNIVERSITY GENERAL DENTISTRY, as long as you have any balance remaining in this office.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court cost, collection agency fees, rebilling fees, late fees and attorney fees.

Patient/Guardian/Responsible Party **(SIGN NAME)** _____ **Date** _____

Office Representative **(SIGN NAME)** _____ **Date** _____

BROKEN/CANCELLED APPOINTMENT POLICY

We make every effort to be on time for our patients and ask that you extend the same courtesy to us and other patients. We strive to have timely appointments available to patient that need to be seen quickly. Therefore, we need to be notified with in 24 hours if you are unable to keep an appointment, so that we may offer that time to someone who has an immediate need. Certainly, emergencies such as illness to occur and we do not wish to penalize patients for unavoidable situations; however, we do want to discourage repeated abuse of our scheduling process, which is ultimately unfair to those who are diligent about keeping their appointments.

If you are more than ten minutes late for an appointment and there is not enough time remaining in the schedule to complete your planned treatment before our next patient is due, your appointment may need to be rescheduled for a mutually convenient day and time.

IN ANY CASE, A CANCELLATION FEE OF $50.00 MAY APPLY.

I have read the above information. **I UNDERSTAND MY RESPONSIBILTY TO COMPLY WITH THIS POLICY & THE CHARGES THAT MAY APPLY IF FAIL TO DO SO.**

Patient/Guardian/Responsible Party **(SIGN NAME)** _____ **Date** _____

University General Dentistry

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 of 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.

OFFICE CONTACT INFORMATION:

Dr. Stan Turnipseed, Dr. William Roe, Dr. David Nelson, Dr. Kristen Reed, Dr. Adam King

Telephone: 205-553-5888 / Fax: 205-553-4119

Address: 601 Helen Keller Blvd. Tuscaloosa, Al 35404

Email: records@ugdsmiles.com

UNIVERSITY GENERAL DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT _____

_____

I, (PRINT NAME) _____, have received a copy of this office's Notice of Privacy Practices and understand that I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PRINT NAME _____ SIGN NAME _____ DATE _____

IF CONSENT IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

PRINT NAME _____ SIGN NAME _____ DATE _____

You are entitled to a copy of this consent if you so desire. Refusal to sign this form will prohibit us from completing certain tasks on your behalf such as filing insurance, confirming your appointment, calling in prescriptions, arranging appointments for you at other offices and mailing re-care cards among other things.

Alternative People Communication Authorization Form

Patient Name: _____ SSN _____

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner as possible. There are certain occasions when family members, friends or others might be involved in your case as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.
Please list below any other people with whom you authorize our office to discuss aspects related to your care.

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Do we have permission to leave messages on voice mail or answering machines?

YES _____ NO _____

Patient/Responsible Signature: _____ Date: _____