TigerTown
FAMILY DENTISTRY
STEPHANIE SIMMONS, DMD
JOSIE REYNOLDS, DMD

Welcome to our Practice!

We are delighted that you have selected our office for your dental care. To assist us in providing you with excellent service, please take a few minutes to print the enclosed forms and complete them prior to your arrival.

Please do not hesitate to call us if we can answer any questions about these forms or your first visit with us.

We look forward to meeting you!
Dr. Stephanie Simmons, Dr. Josie Reynolds & Team

TigerTown Family Dentistry
Stephanie Simmons, DMD
Josie Reynolds, DMD
2542 Enterprise Drive
Opelika, Alabama 36801
(334) 737-6261
www.TigerTownDentistry.com

TigerTown Family Dentistry

Stephanie Simmons, DMD Josie Reynolds, DMD

PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder Preferred Name: _____

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2 — Section 3

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Employer ID: _____

Carrier ID: _____

I was referred by: _____

My Emergency Contact is _____

Emerg. Contact Phone#: _____

Pref. Pharmacy: _____

Dental Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City,State,Zip: _____

Ins. Company: _____

Contract #/Member ID: _____

Group #: _____

Customer Service #: _____

Rem. Benefits: _____ Rem. Deduct: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I _____ have received a copy of this office's Notice of Privacy Practices.
(Please Print Name)

_____

Patient Signature (or Parent/Guardian if minor) Date

TigerTown Family Dentistry

Stephanie Simmons, DMD Josie Reynolds, DMD

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please complete a medication list (enclosed).

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Physician's Name: _____

Address: _____

Phone: _____

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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, PARENT, or GUARDIAN _____ DATE _____

TigerTown Family Dentistry

Stephanie Simmons, DMD Josie Reynolds, DMD

Medication List

If you are taking any medications, please complete this form.

My Name is _____

My Health Care Provider's Name is _____

My Health Care Provider's Phone Number is _____

I am currently taking the following medications:

Medication	When I take it	Dose	Other Instructions

2542 ENTERPRISE DRIVE
OPELIKA, AL 36801
AUBURN • OPELIKA 334.737.6261

TIGERTOWN FAMILY DENTISTRY
STEPHANIE SIMMONS, DMD JOSIE REYNOLDS, DMD

TIGERTOWN FAMILY DENTISTRY PATIENT AGREEMENT

We are committed to providing you with the best possible care. In order to achieve these goals, we ask for your assistance and understanding of our financial and scheduling policies.

Financial Policy

- Payment for services rendered is due and payable at the time of treatment. We accept Cash, Visa, Mastercard, American Express and Discover.
- We have an agreement with CareCredit® and LendingClub® patient financing, third party financing companies, which may afford you the opportunity to make monthly payments for your treatment. Please inquire if you are interested in applying.
- Minor Children: The parent or guardian that brings a minor child in for treatment in our practice is responsible for payment for services.
- Administrative Fees and Interest: There is a $30 service charge for returned checks. Account balances that are 30 days or more past due are subject to 1½% monthly interest (18% annual percentage rate (APR)).

Dental Insurance:

- Dental insurance amounts are estimated coverage only; the estimated patient share of fees is required at the time of service. The patient/responsible guardian is responsible for amounts not covered by insurance or claims not paid within 60 days from date of service. Balances owed are subject to interest and collection practices of this office.
- Secondary Dental Insurance Coverage: We do not file claims with secondary insurance plans in our practice; we will provide you with the necessary information to file these claims to reimburse you directly. Any financial arrangements made in our practice will be based on primary coverage only.
- If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Appointment Policy:

- We do not double-book appointments in our office, and request 2 business days' notice for all cancellations of appointments. Broken appointments or late cancellations of appointments with less than 24 hours notice are subject to a $50 fee.
- We ask for your cooperation in managing your appointments so that we can maintain the greatest possible access to care for each of our valued patients.

Acknowledgement:

I have been informed of TigerTown Family Dentistry financial and appointment policies. I agree to be responsible for all fees incurred during the course of my treatment.

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

_____ _____

Signature of Patient or Responsible Party Date

TIGERTOWN FAMILY DENTISTRY
STEPHANIE SIMMONS, DMD JOSIE REYNOLDS, DMD

Dental Insurance Signature on File:
I hereby authorize payment of the insurance benefits otherwise payable to me directly to TigerTown Family Dentistry.

_____ _____
Signature Date

Consent to Contact:
You agree, in order for us to service your account or to collect monies you may owe. TigerTown Family Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that TigerTown Family Dentistry, its employees and/or agents may contact me/us as described above.

_____ _____
Signature Date

TIGERTOWN FAMILY DENTISTRY
STEPHANIE SIMMONS, DMD JOSIE REYNOLDS, DMD
2542 ENTERPRISE DRIVE • OPELIKA, AL 36801
Phone (334) 737-6261

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 protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect August 1, 2012 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 provide the new Notice at our practice location, and we will distribute it 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.

YOUR AUTHORIZATION: In addition to our use of your health information for the following purposes, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you without authorization for the following purposes:

TREATMENT: We may use or disclose your health information for your treatment. For example, we may 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. 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, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

TO YOU OR YOUR PERSONAL REPRESENTATIVE: 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 your personal representative, 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 health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in 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 forms of health information.

DISASTER RELIEF: We may use or disclose your health information to assist in disaster relief efforts.

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.

PUBLIC HEALTH AND PUBLIC BENEFIT: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

DECEDENTS: We may disclose health information about a decedent as authorized or required by law.

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 under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, emails, postcards, or letters).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we may charge you for staff time to copy your health information, 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 August 1, 2012. 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. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket 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.

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: 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 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.

CONTACT OFFICER: Stephanie Simmons, DMD or Josie Reynolds, DMD
TELEPHONE: (334) 737-6261
ADDRESS: 2542 Enterprise Drive, Opelika, AL 36801

TigerTown Family Dentistry
Stephanie Simmons, DMD Josie Reynolds, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this acknowledgement*

Name: _____

DOB: _____

Social Security #: _____

I authorize the following for reminders of my appointments:

- ☐ Open Correspondence
- ☐ Messages at work Wk# _____
- ☐ Messages on Cell Cell# _____
- ☐ Text Messages Cell# _____
- ☐ Messages at home Hm# _____
- ☐ Email Email _____
- ☐ Postcard Address _____

_____

I authorize person(s) to whom my medical and dental information may be released:

Name	Relationship	Contact#
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have read the consent of this authorization form and I agree with all statements made. I understand that, by signing this form, I am confirming my authorization fo use and/or disclosure of the protected health information described in this form with the people and/organizations named in this form.

X_____ _____
Sigature of Patient (Guardian) Date

I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

X_____ _____
Sigature of Patient (Guardian) Date

TigerTown FAMILY DENTISTRY
STEPHANIE SIMMONS, DMD
JOSIE REYNOLDS, DMD

Photo Consent Form

Photo Consent Form By checking the boxe(s) below, you are authorizing our office to use your images for the purpose of dental education. We often do social media posts such as before and afters when a patient undergoes a dental transformation. You will not be identified by name in any way, but your images will be seen.

☐ I authorize the use of my images where my face and teeth are identifiable

☐ I authorize the use of my images where only my teeth are identifiable

We understand that this may be a situation in which you are not comfortable with and would prefer to opt out of. By signing the box below you are prohibiting Tiger Town Family Dentistry from using images of your teeth and or face for any reason.

☐ I do not authorize Tiger Town Family Dentistry to use any images of my face or teeth for any reason

By signing this form you hereby declare that the options you have selected are what you wish to consent to.

_____

Patient Name (Printed)

_____

Patient Name (Signature) Date