TODD WHITLOCK, DDS
3671 S. Sare Rd.
Bloomington, IN 47401
(812) 332-0052

Patient Information

Name _____ Gender: M☐ F☐ Other☐ _____

Marital Status: ☐ Single ☐ Married ☐ Other

Date of Birth _____ Age _____ SS# _____

Home Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone _____ Work Phone _____ Ext. _____

Cell Phone _____

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Employer/School _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Person Responsible for Account _____ Phone _____

Billing Address _____

City _____ State _____ Zip _____

Spouse/Guardian's Name _____ Employer _____

Spouse/Guardian's Occupation _____ Work Phone _____

Emergency Contact Name/Relationship: _____ Phone:_____

Please Share With Us…

How were you referred to our office?

☐ Family or Friend: _____ ☐ Drive by/location ☐ BLOOM

☐ Website ☐ Facebook ☐ Google

☐ Doctor: _____ ☐ Healthgrades

☐ Other: _____ ☐ Radio

Previous Dentist_____ Date of last dental visit _____

Your children's names and ages:

_____

What will keep you as a long term patient in our practice?

_____

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Insurance Information

Name of Insured _____ Date of Birth _____ SS # _____

Insurance Co. Name _____

Phone _____

Name of Employer Group Plan _____ Policy # _____

Claim Filing Address _____

City_____ State_____ Zip _____

- ☐ I authorize use of this form on all my insurance submissions.
- ☐ I authorize release of information to all my insurance carriers.
- ☐ I understand that I am responsible for my bill.
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ☐ I authorize payment directly to my doctor.
- ☐ I permit a copy of this authorization to be used in place of the original.

Payment Options:
Please check preferred option:

- ☐ Visa/MasterCard
- ☐ Cash
- ☐ Check
- ☐ American Express
- ☐ Discover

Signature on File _____ Date _____

Consent: I grant authority to TODD WHITLOCK, D.D.S. to perform dental procedures and treatments that may be necessary.

Signature_____ Date_____

TODD WHITLOCK, D.D.S.
3671 S. Sare Rd.
Bloomington, IN 47401
812-332-0052

MEDICAL HISTORY

PATIENT NAME:_____ **DATE:**_____

Have you had any of the following at any time?

YES	NO	
☐	☐	Cardiovascular Disease
☐	☐	Heart attack
☐	☐	Angina
☐	☐	Heart murmur
☐	☐	Pacemaker
☐	☐	Prosthetic heart valve
☐	☐	Congestive Heart Failure
☐	☐	Prosthetic joint implants - Do you require an antibiotic before dental procedures? Yes or No
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood or bleeding problems
☐	☐	Stroke
☐	☐	Rheumatic fever
☐	☐	Skin problems, hives, or rashes
☐	☐	Thyroid Disease or Thyroid problems
☐	☐	Kidney Disease
☐	☐	Diabetes
☐	☐	Stomach problems or intestinal problems
☐	☐	Epilepsy
☐	☐	Fainting spells or seizures
☐	☐	Nervous condition
☐	☐	Fever blisters or cold sores
☐	☐	Sinus trouble
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	Hepatitis, Jaundice, or Liver Disease
☐	☐	Systemic Lupus
☐	☐	Rheumatoid arthritis
☐	☐	Emphysema/COPD
☐	☐	Asthma
☐	☐	Herpes
☐	☐	Venereal disease (gonorrhea, syphilis)
☐	☐	Glaucoma
☐	☐	Hearing Aid
☐	☐	AIDS or HIV infection
☐	☐	Tuberculosis
☐	☐	Cancer, Type and Treatment_____
☐	☐	Alcoholism
☐	☐	Drug addiction
☐	☐	Tobacco habit
☐	☐	Seasonal Allergies (Hay fever)
☐	☐	Latex sensitivity or allergy
☐	☐	Are you allergic to any medications? Please List:_____
☐	☐	Are you currently taking any medications (including aspirin)? Please List:_____
		_____
☐	☐	Are you currenlty or have you taken bone density medications? Please List drug name and dates taken:_____
		_____
☐	☐	Are your immunizations current? Covid vaccinated? ☐ Yes ☐ No
☐	☐	Are you in good health?
☐	☐	Are you pregnant?
☐	☐	Do you have any disease, condition, or problem not listed?_____
		_____

Physician's Name:_____

Physician's Phone:_____

Physician's Address:_____

Pharmacy:_____

If you could change anything about your smile, what would it be?

☐younger ☐cover stains
☐lengthen teeth ☐shorten teeth
☐brighter ☐straighten teeth
☐close spaces ☐repair chipped teeth
☐replace missing teeth
☐other: _____

Please check any of the following conditions that apply to you.

☐bad breath
☐bleeding gums
☐clicking or popping jaw
☐food collection between teeth
☐grinding teeth
☐loose teeth or broken fillings
☐periodontal treatment
☐sensitivity to cold
☐sensitivity to heat
☐sensitivity to sweets
☐sensitivity when biting
☐sores or growths in your mouth

The above information is accurate to the best of my knowledge.

Patient Signature_____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Todd Whitlock, D.D. S
3671 S Sare Rd
Bloomington, IN 47401
812-332-0052
twhitlockdds@aol.com
Privacy Officer: Todd Whitlock

For more information about HIPPA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
202-619-0257
877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Dr. Whitlock at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices/Patient Consent, but was unable to do so as documented below:

Date:	Initials:	Reason:

Todd Whitlock, D.D.S.
3671 S. Sare Rd.
Bloomington, IN 47401
(812) 332-0052

Patient:_____ **Date:**_____

Financial Options

In our office, we do not want money to be a problem for you. We want you to feel comfortable and satisfied with the financial arrangements regarding your dentistry. We encourage you to enter into a financial arrangement that is comfortable for you. For your ease and convenience, we offer several types of financial options.

1. **Payment in Full**
   Payment in full is required when treatment begins. For your convenience, we accept *Visa*, *Mastercard*, *Discover*, and *American Express* as well as, *cash* or *check*.

2. **Two Equal Payments**
   Payment may be divided into two equal payments for procedures that require more than one appointment. One half is to be paid on the day treatment begins; the remaining half is to be paid when treatment is complete.

3. **Care Credit Finance**
   The total fee may be paid in 12 months same as cash. Minimum amount of $300.00 and higher financed. *Good credit standing required.*

4. **Dental Insurance**
   Co-pay is required the day of service for all restorative, periodontal, and endodontic treatment.

I accept option #_____ to pay for my dental treatment.

- I agree to pay all bills submitted to me and/or resulting from services provided by Provider. Accounts over thirty days old will be charged a late fee of **$100.00** to offset Provider's expenses in billing and collecting your overdue account prior to referring your account for collection by an agency or attorney.
- Should the account be referred for collection, I agree to pay any and all reasonable attorney's fees and court costs. Reasonable attorney fees shall include, but not be limited to, any and all attorney fees charged in preparing, filing and obtaining a judgment against me, in addition to attorney fees charged in collecting upon a judgment by way of proceedings supplemental, garnishment or any other reasonable post-judgment collection method.
- If any provision of the Agreement, or any portion thereof, is held to be invalid and/or unenforceable, then the remainder of this Agreement shall nevertheless remain in full force an effect.

_____ _____

Patient Signature **Date**