TUMLIN FAMILY DENTISTRY

PATIENT INFORMATION

Thank you for choosing Tumlin Family Dentistry for your dental care. Please complete the information below so we can ensure that our records are up to date.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: _____ Employer: _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

ADDRESS AND HOME PHONE

Check box if same for entire family: ☐

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Emergency Contact

Name: _____ Phone Number: _____

How did you hear about us? _____

Please complete the following if you have dental insurance benefits.
PLEASE PROVIDE A COPY OF YOUR CARD TO THE FRONT OFFICE STAFF.
****Please note: Tumlin Family Dentistry is out of network, but will file as a courtesy. Our system will give us an expected patient and insurance portion. We do collect the patient portion at time of service.**

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist so that it can be scanned and verified.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

By signing this form, I agree that the information above is correct and current.

_____ _____
Signature Date

TUMLIN FAMILY DENTISTRY

Patient Authorization for Use and Disclosure of Protected Health Information

This form is used to ensure your health information is protected and communicated only as released. Please ensure it is completed fully.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____

Address: _____

Address 2: _____

City: _____ State: Zip: _____

Cell Number: _____ Home/ Additional Number: _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Preferred Contact Method for Confirmations: ☐ Home Phone ☐ Work Phone ☐ Wireless Phone ☐ Email ☐ Text

Do you consent to voicemails and/or texts to include detailed messages with appointment and minimal health information? **Yes** ☐ **No** ☐

I authorize Tumlin Family Dentistry to share protected health information with the following:

Name: Relatationship: Phone #: _____

Name: Relatationship: Phone #: _____

Name: Relatationship: Phone #: _____

Information okay to be disclosed:

☐ All dental information ☐ Billing/ Account Information ☐ Specific Information Only: _____

Authorization Statement: I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to Tumlin Family Dentistry directly. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that I can request a copy of this authorization.

_____
Patient or Legal Guardian Signature

_____
Patient or Legal Guardian Name (printed)

_____
Date

_____
Relationship (if not the patient)

Expiration Date: This authorization remains in effect until it is revoked in writing or replaced by a newly completed form.

Cavity Risk Assessment

Date: _____

Patient Name: (Last) _____ (First) _____ **Birthdate:** _____

Check next to any of the following that you drink or eat

- ☐ Peppermints
- ☐ Altoids
- ☐ Jolly Ranchers
- ☐ Breath Mints
- ☐ Lollipops
- ☐ Gum
- ☐ Air Heads
- ☐ Sour Candies
- ☐ Cough Drops

Any other hard candies: _____

Any other _____

- ☐ Sweet Tea
- ☐ Coffee
- ☐ Energy Drinks
- ☐ Juices Type: _____
- ☐ Soft Drinks Type: _____
- ☐ Apple Cider Vinegar
- ☐ Drink Powders

FOR TODDLERS:

☐ Uses a sippy cup ☐ Uses a pacifer ☐ Uses a bottle Contents in bottle/sippy: _____

Do you use any tobacco products?

☐ Yes ☐ No What type? _____ Frequency? _____

Do you have trouble falling asleep? ☐ Yes ☐ No **Do you snore?** ☐ Yes ☐ No

Do you wake feeling rested? ☐ Yes ☐ No **Do you use a C-PAP machine?** ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Do you clench or gring your teeth? ☐ Yes ☐ No **Do you experience dry mouth?** ☐ Yes ☐ No

How often do you brush your teeth? _____ **Floss?** _____

What kind of toothpaste do you use: ☐ Regular ☐ Gel ☐ Tarter Control ☐ Whitening ☐ Desensitizing

Are you using a FLOURIDE mouthwash? ☐ Yes ☐ No

Do you have any sensitivity, soreness, or problems with your teeth or gums that we need to be aware of?

_____

_____

TUMLIN FAMILY DENTISTRY

MEDICAL HISTORY

Last Name: _____ First Name: _____ Birthdate: _____

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 medications that you may be taking, could have an important interrelationship with the dental care you will receive. Thank you for completing the following information.

List all medications that you are currently taking: **** Check box on any medications you are NO longer taking.**

1. ☐ _____
2. ☐ _____
3. ☐ _____
4. ☐ _____
5. ☐ _____
6. ☐ _____
7. ☐ _____
8. ☐ _____
9. ☐ _____
10. ☐ _____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic	☐	☐	Iodine
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Ibuprofen	☐	☐	Sulfa

Other allergies not listed above:

_____

Do you have any of the following medical conditions?

Y	N		Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐	Arthritis	☐	☐	Eye, Ear, Nose Problems
☐	☐	Bleeding Problems	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐	Hepatitis
☐	☐	Cancer _____	☐	☐	Pregnancy	☐	☐	STD/ STI	☐	☐	COPD
☐	☐	Diabetes	☐	☐	Psychiatric Treatment	☐	☐	Thyroid Disease	☐	☐	Sleep Apnea
☐	☐	Epilepsy	☐	☐	Rheumatic Fever	☐	☐	Fainting Spells			**Women:**
☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐	X-Ray Therapy	☐	☐	Currently Pregnant
☐	☐	Heart Trouble	☐	☐	Stroke	☐	☐	AIDS	☐	☐	Currently Nursing
☐	☐	High Blood Pressure	☐	☐	Strep Throat	☐	☐	Stomach/Intestinal Issues			
☐	☐	Joint Replacement	☐	☐	Ulcers	☐	☐	Circulatory Problems			

Other conditions not listed above:

_____

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

New Patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former Dentist: _____ City/State: _____

Date of last cleaning and exam: _____

_____ **Date:** _____

Patient/Guardian Signature

Tumlin Family Dentistry
701 N. Tennessee Street
Cartersville, GA 30120

Privacy Policies and Procedures
Your Information. Your Rights. Our Responsibilities.

This is a simplified summary of our complete Privacy Policy and Procedures.
Please request the full version if you wish to review it in detail.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Last Updated: June 9, 2025
Privacy Officer: Hayley Tirey

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient: _____ DOB: _____

By my signature below, I acknowledge that I have received either a paper or an electronic copy of the **HIPAA NOTICE OF PRIVACY PRACTICES** for **Tumlin Family Dentistry** (herein the "Practice"). I also understand that I am entitled to receive a paper copy of the HIPAA **NOTICE OF PRIVACY PRACTICES** upon request, even if I have previously agreed to receive only an electronic copy.

Signature: _____ Date: _____

If applicable:
Representative Name: _____ Date: _____

Relationship to patient: _____

FOR OFFICE USE ONLY: *Only if the acknowledgment above is not signed by the patient or the patient's representative.*

A good faith effort was made to obtain a written **ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**, but could not be obtained because *(please check as appropriate)*:

_____ Refusal by patient or patient's representative.
_____ A communication barrier prevented obtaining a signature.
_____ An emergency situation prevented obtaining a signature.
_____ Other: _____.

Staff Member: _____ Date: _____

TUMLIN
FAMILY DENTISTRY

Last Name: _____ First Name: _____ Birthdate: _____

PLEASE REVIEW AND SIGN FORM INDICATING UNDERSTANDING

APPOINTMENTS: I understand that a 24 hours notice is expected for cancellation of appointments. A minimum charge may be made for a failed appointment without 24 hours prior notification. This charge will be $35 per half -hour of your scheduled appointment time. For example, a 45 minutes failed appointment fee would be $52.50. A 2 hour failed appointment fee is $140.00.

RELEASE OF PROTECTED INFORMATION: I consent to the release of encrypted or unencrypted radiographic images, and other HIPAA protected information, as necessary for referrals to/from any other health or dental care provider and/or the processing of insurance claims. I understand that unencrypted information may be compromised.

INSURANCE AND PAYMENTS: I understand that all professional services are charged directly to the patient or the responsible party, and that party is personally accountable for the payment of fees at the time of service. Tumlin Family Dentistry is NOT a participating provider in any insurance company network.
The practice will prepare the necessary forms or reports to help the responsible party obtain insurance benefits, as long as they have been provided with correct and current information. This is done as a courtesy, and Tumlin Family Dentistry does not render services on the basis that insurance companies will pay all of their fees. Each fee is individual for the individual patient, and the patient (parent or guardian) is personally responsible for any amount that the insurance company does not pay. Financial arrangements must be made in advance.

DENTAL TREATMENT CONSENT: I understand the Covid virus and its variants, as well as other illnesses, have incubation periods during which carriers may not show symptoms and still be highly contagious, and that it is impossible to determine who may or may not have an illness.
I understand that while this office is taking every recommended precaution to reduce risk, dental procedures do create water spray (aerosols). The ultra-fine mist of the spray can linger in the air for several minutes to hours, and may be one way disease is spread.
I understand that due to the frequency of visits of other dental patients and the characteristics of dental procedures, that the patient (parent or guardian) may have an elevated risk of contracting an illness by being in a dental office.

FOR THE COMFORT OF OTHER PATIENTS AND STAFF MEMBERS, PLEASE DO NOT WEAR COLOGNE OR PERFUME TO YOUR APPOINTMENT.

I have read and I understand and agree with the above information. I understand that this form has no expiration unless revoked with a written request.

_____ Date: _____

Patient/Guardian Signature