

Notice of Privacy Practices

Federal & State laws require Tatum Point Dentistry to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations, and your rights in regard to your child's healthcare information. Tatum Point Dentistry must follow the privacy practices as described within this notice while this policy is in effect. This notice takes effect on February 1st, 2008 and will remain in effect until replaced, amended, or eliminated.

Tatum Point Dentistry reserves the right to change these privacy practices and the terms of this notice at any time provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make any significant changes to our privacy practices, we will change this notice and make new notice available upon request.

Parent or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPAA) Manual, please contact our office at any time.

USES & DISCLOSURES OF HEALTHCARE INFORMATION

Tatum Point Dentistry will use and disclose patient healthcare information during your treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

Treatment. Tatum Point Dentistry may use your health information during direct treatment or by disclosing such information to other dentists, physicians or healthcare providers who may provide specialized treatment for you.

Payment. We may also use and disclose your health information to obtain payment for services rendered. We may disclose your healthcare information to another healthcare provider or entity that is also subject to these same federal & state privacy rules and regulations for payment activities.

Healthcare Operations. We may use and disclose your healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities. We may disclose your healthcare information to another healthcare provider or organization that is subject to the same federal & state privacy rules and regulations and that has a relationship with you during the support of healthcare operations. We may disclose your information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals, or detect or prevent healthcare fraud or abuse.

On Your Authorization. You may give Tatum Point Dentistry written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any issues or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described within this notice.

To Your Family & Friends. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for previously performed healthcare services. Before we disclose your health to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for yourself, or in the event of an emergency, we will disclose your medical information based on our professional judgment of practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, radiographs or other similar forms including health information. We may also use or disclose information about you to notify or assist in notifying a person involved in his/her care.

Appointment Reminders. Tatum Point Dentistry may use or disclose your healthcare information to provide you and your family with appointment reminders. (Such as: telephone calls, voice messages, postcards, or letters)

Disaster Relief. We may use or disclose your healthcare information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law

- For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight and to employer's regarding work-related illness or injury.
- To health oversight agencies
- In response to court and administrative orders and lawful processes
- To law enforcement officials pursuant to subpoena and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and for purposes of identifying or locating a suspect or other persons.
- To coroners, medical examiners and funeral directors
- To an organ procurement organization
- To avert serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities
- To correctional institutions regarding inmates
- As authorized by state worker's compensation laws

PATIENT or PARENT/LEGAL GUARDIAN RIGHTS

Access. You have the right to look at or receive a copy of your health information, with limited expectations. You may request that we provide a copy in format other than photocopies. We will use the format you request unless we cannot practically do so. You must make all requests in writing to obtain access to your child's healthcare information. You may request access by sending us a letter. If you request a copy, we will charge you a reasonable fee, which may include labor, copying costs and postage. 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 may, but are not required to, prepare a summary or an explanation of your health information for a fee.

Disclosure Accounting. You have the right to receive a list of instances in which Tatum Point Dentistry or any business associates disclosed your health information over the past year (but not prior to June 24th 2010). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you and certain activities. 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 the use or disclosure of your healthcare information. We are not required to agree with such additional restrictions, but if we do, we will abide by our agreement (except in the event of an emergency). Any agreement we make to a request for additional restrictions must be in writing and signed by our privacy officer. Your request is not binding unless our agreement is in writing.

Alternative Communication. You have the right to request that we communicate with you about your health information by an alternative means or at an alternative location. You must make your request in writing. You must specify in your request the alternative means or location and satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment. You have the right to request that we amend your healthcare information. Your request must be in writing and should explain why you are requesting this amendment. We may deny your request under certain circumstances.

QUESTIONS OR COMPLAINTS

If you need additional information regarding our office's Privacy Practices & Regulations or have specific questions or concerns, please feel free to contact us. Furthermore, if you believe that:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly
- Our response to a previous request to amend or restrict the use or disclosure of your information was incorrect
- We should communicate with you by alternative means or an alternative location

You may submit a written complaint with our privacy officer or directly to the US Department of Health & Human Services. We will provide you with these addresses to file your complaint, upon request. We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health & Human Services.

I understand the contents of the previous notice concerning the privacy of my confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Tatum Point Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

Signature of Patient/ Parent or Guardian

Date

Patient Information

Please Print

Title: _____ First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Patient Social Security #: _____ Patient Date of Birth: _____ Sex: M ☐ F ☐

Email Address: _____ May we contact you by email? Yes ☐ No ☐

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

**If patient is under the age of 18, Parent or Guardian please fill out below:*

Parent / Guardian Name: _____

Date of Birth: _____ Social Security #: _____

Insurance Information

Do you have Dental Insurance? Yes ☐ No ☐

Primary Insurance	Secondary Insurance
Subscriber Name: _____	Subscriber Name: _____
Subscriber SSN: _____	Subscriber SSN: _____
Date of Birth: _____	Date of Birth: _____
Relationship to Subscriber: Self Spouse Child Other	Relationship to Subscriber: Self Spouse Child Other
Employer Name: _____	Employer Name: _____
Employer Phone: _____	Employer Phone: _____
Insurance Company: _____	Insurance Company: _____
Insurance Group # _____	Insurance Group # _____
Insurance Phone # _____	Insurance Phone # _____
Insurance Address: _____	Insurance Address: _____

Please present insurance card and Drivers License

Dental Practice Policies

Dear Patient:

Welcome to our dental office. We appreciate the opportunity to assist you with your dental care needs. Our goal is to provide you and your family with the best dental care available at an affordable cost and in an efficient and professional manner. We can only accomplish this goal with your help. With this in mind, we have listed our office policies below for your review.

_____ **Should you be unable to make your scheduled appointment we request that you notify the office at least 48 hours in advance.** We will make every effort to confirm your appointment with you; however, it is your responsibility to keep that appointment. A broken appointment fee of **\$100.00** may be billed to your account if you fail to notify the office within the time frame specified.

_____ Payment is due at the time of service. We accept cash, money orders, debit cards and all major credit cards as payment. For your convenience, we accept most dental insurances. As a courtesy, we will be happy to file your dental insurance claim to your insurance company on your behalf. **Insurance claims that are not paid within (60) days become the sole responsibility of the patient. If the balance on your account becomes more than (90) days past due, your account will be transferred to a collections agency and a fee of 30% of the balance will be added to your account.**

_____ We try very hard to adhere to a schedule. If you are more than 15 minutes late, we may have to reschedule your appointment. Sometimes an emergency will occur that will make us run behind. We do respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our dental family and look forward to a long relationship with you.

_____ Please understand that dentistry is **not** an exact science and therefore reputable practitioners cannot properly guarantee results. No guarantee or assurance has been made by anyone regarding dental treatment that you have requested or authorized. Each dentist is an individual practitioner and is individually and solely responsible for the dental care rendered.

_____ Your original records belong to the office. You may request copies for you or others. We will provide them within five business days upon receiving a written request from you. There will be a fee to duplicate your chart.

_____ The patient and dentist (including their corporations, representatives, staff, agents, parents, guardians, children and all related individuals and entities) agree that all litigation events that occurred in the dental office will be determined through submission to an arbitrator, and NOT by a lawsuit or other legal proceeding filed in a federal, state, county or municipal court. By signing this Arbitration Agreement, the parties waive and forfeit their constitutional, statutory or common law rights for a jury or judge to decide any legal questions or disputes, and instead accept the sole use of a private arbitrator. This Arbitration Agreement covers all disputes as to dental treatment, financial matters or any other events that occurred in dental office whether in tort (intentional or negligent), contract, statute, common law or otherwise, and including without limitation all actions relating to dental negligence, return of fees, loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. The arbitration shall bind all parties, including without limitation any spouse or heirs, and will NOT be subject to court review. Either party may initiate arbitration by serving on the other a written "Demand for Arbitration" form by certified mail. No other form of service will be acceptable. The Demand for Arbitration must identify all parties, include their contact information, describe the claims against each party, and state the amount of damages sought. Either party then may continue the proceedings by contacting the American Arbitration Association ("AAA"). A single AAA arbitrator, mutually selected by the parties, will conduct the arbitration. All proceedings will be resolved using the AAA rules. Arizona law will apply. If any provision of this Arbitration Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and effect.

Patient Signature: _____

Witness Signature: _____

Patient Print Name: _____

Witness Print Name: _____

Date: _____

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION FORM

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, insurance providers and primary care doctors, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

Authorization to Speak with Family/Friend (including spouses)

I give the following named person(s) authorization to take messages or speak with the office of Tatum Point Dentistry on my behalf regarding (please check all items authorized):

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

Name of Authorized person: _____ Relationship: _____

Phone Number: _____

Appointments Financial Dental Treatment Insurance Other

I understand my express consent is required to release my health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed below.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

To our patients: Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat you.

© 2026 American Dental Association
Form S50026 To reorder call 800.947.4746 or go to [ADAstore.org](https://ada.org/store).

ALLERGIES Please use an “X” to mark your answers to the following questions.

Are you allergic to or have you had an allergic reaction to:	Yes	No	?	Yes	No	?
Aspirin	☐	☐	☐	Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim),		
Barbiturates, sedatives or sleeping pills	☐	☐	☐	erythromycin-sulfisoxazole, sulfasalazine (Azulfidine), erythromycin-		
Codeine or other narcotics	☐	☐	☐	sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs),		
Hay fever/seasonal allergies	☐	☐	☐	dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide		
Iodine	☐	☐	☐	(Microzide) and furosemide (Lasix).	☐	☐
Latex (rubber)	☐	☐	☐	Other	☐	☐
Local anesthetics	☐	☐	☐	Please describe any “Yes” answers and include information about your experience.		
Metals	☐	☐	☐			
Penicillin or other antibiotics	☐	☐	☐			

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / /	What is your normal blood pressure (systolic, diastolic)?
Doctor’s Name:	Phone:

Please use an “X” to mark your answers to the following questions.

	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	☐	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Have you had any type (either total or partial) of joint replacement surgery (such as for a hip, knee, shoulder, elbow, finger, etc.)?	☐	☐	☐
Have you had a heart valve replacement or heart surgery ?	☐	☐	☐
Have you had an organ or bone marrow/stem cell transplant ?	☐	☐	☐
Have you traveled internationally within the last 30 days	☐	☐	☐
Have you had a fever (100.4°F or above) in the last 72 hours?	☐	☐	☐
If you answered yes to any of the above, please explain:			

MEDICAL HISTORY SPECIFIC Please use an “X” to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?							
	Yes	No	?		Yes	No	?
Heart (Cardiac) Health				Cancer	☐	☐	☐
Pacemaker/implanted defibrillator	☐	☐	☐	Type:			
Artificial (prosthetic) heart valve	☐	☐	☐	Date of diagnosis:			
Previous infective endocarditis	☐	☐	☐	Chemotherapy:			
Congenital heart disease (CHD)	☐	☐	☐	Radiation treatment:			
Unrepaired, cyanotic CHD	☐	☐	☐	Blood (Circulatory) Health			
Repaired (completely) in last 6 months	☐	☐	☐	Anemia	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐	Blood transfusion	☐	☐	☐
Arteriosclerosis	☐	☐	☐	If yes, date:			
Coronary artery disease	☐	☐	☐	Hemophilia	☐	☐	☐
Congestive heart failure	☐	☐	☐	High or low blood pressure	☐	☐	☐
Damaged heart valves	☐	☐	☐	Brain (Neurological)/Mental Health			
Heart attack	☐	☐	☐	Anxiety	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐	Depression	☐	☐	☐
Rheumatic heart disease	☐	☐	☐	Epilepsy	☐	☐	☐
Stroke	☐	☐	☐	Mental health disorders	☐	☐	☐
Breathing (Respiratory) Health				Neurological disorders	☐	☐	☐
Asthma (COPD)	☐	☐	☐	Post-traumatic stress disorder	☐	☐	☐
Bronchitis	☐	☐	☐	Traumatic brain injury or concussion	☐	☐	☐
Emphysema	☐	☐	☐	Autoimmune Disease			
Sinus trouble	☐	☐	☐	AIDS or HIV Infection	☐	☐	☐
Tuberculosis	☐	☐	☐	Lupus	☐	☐	☐

Do you have any disease, condition, or problem that’s not listed here? If so, please explain. _____

MEDICAL SYMPTOMS/GENERAL Please use an “X” to mark your answers to the following questions.

In the past 30 days, have you:	Yes	No	?		Yes	No	?		Yes	No	?
had pain or tightness in the chest?	☐	☐	☐	found it hard to catch your breath?	☐	☐	☐	experienced vomiting, diarrhea, chills,			
coughed up blood or had a cough that				had a high fever (greater than 101.5°F) for				night sweats or bleeding?	☐	☐	☐
lasted longer than 3 weeks?	☐	☐	☐	no reason?	☐	☐	☐	had migraines or severe headaches?	☐	☐	☐
been exposed to anyone with tuberculosis? ..	☐	☐	☐	noticed a change in your vision?	☐	☐	☐	Over the past two weeks , have you felt			
had a rapid or irregular heart beat?	☐	☐	☐	fainted for no reason?	☐	☐	☐	connected to the world around you?	☐	☐	☐

NOTE: It’s important for both the doctor and patient to talk honestly about the patient’s health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____



Oral Abnormality Screening Consent Form

We are very concerned about oral cancer and conduct screening examinations on every patient.

The incidence of Oral Cancer continues to rise in the USA. The American Cancer Society indicates that since 2013, there has been a remarkable 61% increase in this deadly disease. **Alarmingly, over 50% of the new oral cancer cases are people that do not have any of the traditional lifestyle risk factors, such as age, tobacco and alcohol use. However, the fastest rate of Oral Cancer is in patients that do not smoke or drink and are below the age of 36. It is believed that the virus can be TRANSMITTED simply through kissing. Sexually Active, HPV Positive, smokers, 2+ drinks per day, poor access to healthcare, poor diet, and history of cancer in family are at an increased risk. It is now known that the same virus that causes cervical cancer, HPV (Human Papilloma Virus), is now the leading cause of oral cancer.**

VELscope, like other early detection procedures like colonoscopy, mammography, PAP smear and PSA exam, is a painless, non-invasive blue light that is shined into the patient's mouth. The images are viewed through the back of the **VELscope** handpiece, and the hygienist or dentist may find tissue abnormalities at an earlier stage. Before the exam, the room maybe darkened and with the special vision technology the clinician can see changes in tissue that may not be visible to the eye. These detected changes can range from something minor to something of greater concern that may require further examination and follow up.

Prescreening questions:

Have you ever had an oral cancer screening performed? YES NO ☐ ☐

Do you regularly use sunblock to reduce sun exposure? YES NO ☐ ☐

Do you eat a low amount of fruit and vegetables? YES NO ☐ ☐

Have you ever had an area in your mouth that you were/are concerned about (sore, irritation)? YES NO ☐ ☐

If YES, where? _____

Have you ever tested positive for HPV-Human Papillomavirus? YES NO ☐ ☐

Have you ever smoked (cigarettes, pipe, cigars, recreational drugs, vaped or used chew tobacco)? YES NO ☐ ☐

If YES: What is frequency of use (please circle): Daily, Weekly, On Occasion

How much do you smoke/chew during that time? _____

How old were you when you started? _____

How many alcohol drinks per week? (please circle) 0 1-5 5-10 15+

For female patients:

Have you ever had a Pap smear, mammogram or PSA performed? YES NO ☐ ☐

Have you ever had a positive cervical Pap smear? YES NO ☐ ☐

Traditionally, our dentists and hygienists have done oral cancer screening with the naked eye, but recently a new technology, the **VELscope** has received FDA approval. The **VELscope** (for Visually Enhanced Lesion scope) **will help us pinpoint and identify suspicious tissue at earlier stages before they may become life threatening concerns.** Oral cancer is one of the easiest to treat when found early but has one of the lowest survival rates because it generally is found too late.

The VELscope testing is an addition to our traditional visual oral cancer screening and will add only a few minutes to the entire exam. The normal fee for this procedure is \$65, however, the Doctor feels so strongly that every patient has this examination at least once a year our charge for this enhanced examination is only \$45. The encouraging aspect of your insurance is that this is the most you will have to pay out of pocket. As part of our standard of care and because we care about you, we strongly recommend that you choose this additional screening procedure. Please sign the area below to accept the financial responsibility for this procedure.

YES _____ NO _____	
I authorize the office to perform the VELscope examination.	
Print Name _____	
Signature _____	Date _____

ANATOMY CHECKLIST

LIPS

- _____ Upper
- _____ Lower
- _____ Vermilion
- _____ Border
- _____ Commisures

CHEEKS

- _____ Right
- _____ Left

OROPHARYNX

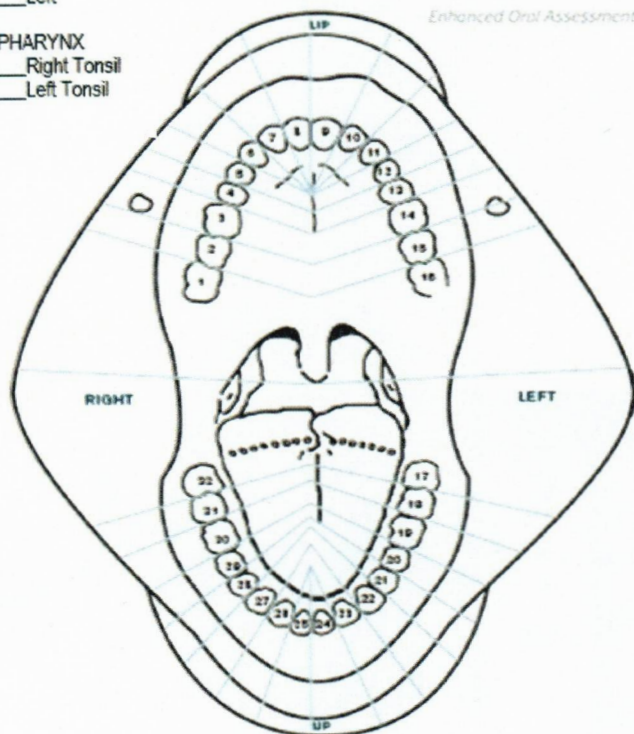
- _____ Right Tonsil
- _____ Left Tonsil

FAUCIAL PILLARS

- _____ Right Posterior
- _____ Right Anterior
- _____ Left Posterior
- _____ Left Anterior

Patient Name _____

Date _____



PALATE

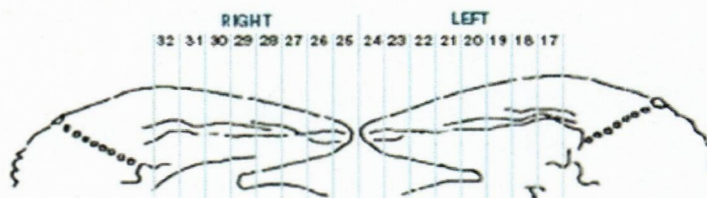
- _____ Uvula
- _____ Soft
- _____ Hard

TONGUE

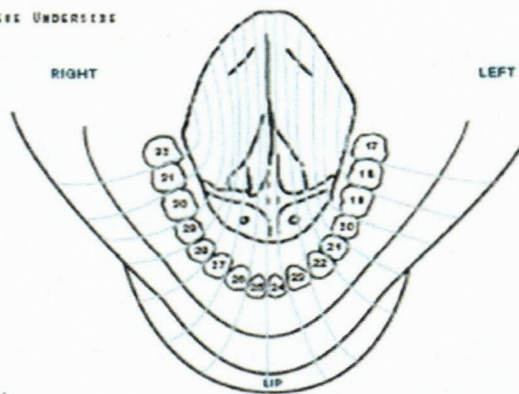
- _____ Dorsum
- _____ Right Lateral Border
- _____ Left Lateral Border
- _____ Ventral

FLOOR

- _____ Wharton's Duct



FORM C: TONGUE UNDERSIDE



CLINICAL

IMPRESSION: _____

CLINICAL

IMPRESSION: _____