

Drs. Birdwell and Guffey
Comprehensive Family Dentistry

Dr. Vicki Davis Guffey, DDS

529 E Gov John Sevier Highway

Phone (865) 573-9629

Dr. Chris R. Birdwell, DDS

Knoxville, TN 37920

Fax (865) 577-3966

Email birdwell-guffey@comcast.net

Website: www.birdwellguffey.com

Welcome to our office! We appreciate your selection of this office to serve your dental health needs and look forward to meeting you.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- We truly care about our patients and want you to feel comfortable in our office and with our entire team.
- We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- We recognize that your time is valuable and we strive to provide treatment in the most efficient and timely manner possible. Our goal is to stay on or ahead of schedule and, thanks to our reliable patients, we usually do. We work with one patient at a time and the time you reserve is yours and yours alone.
- We are passionate about beautiful smiles and good oral health.
- We strive for excellence in providing the highest quality dentistry in a pleasant and organized setting.

Enclosed you will find our new patient information forms. Please fill these out and bring them with you to your first appointment.

We look forward to meeting you.

Sincerely,

Drs. Birdwell, Guffey, and team

DRS. BIRDWELL_GUFFEY, DDS

MEDICAL/DENTAL HISTORY

Patient Name:

Birth Date:

Date Created:

General Single Questions

- Do you have a medical doctor? If yes, please provide name and office phone number. Yes No If yes
- Do you see a specialist for any medical issues? If yes, please provide name and office phone number. Yes No If yes
- Are you under a physician's care now for a particular problem? Yes No If yes
- Have you ever had a serious head or neck injury? Yes No If yes
- Have you ever been hospitalized or had a major operation? Yes No If yes
- Do you take medications? If yes please list or provide a list, prescription and over the counter Yes No If yes
- Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes
- Are you on a special diet? Yes No If yes
- Do you smoke or use any type of tobacco products? Yes No If yes
- Do you use controlled substances? Yes No If yes
- Have you ever taken Fosamax, Boniva, Actonel, Redast, Aredia, Zometa for Osteoporosis? Yes No If yes
- Women Only: Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Yes No If yes

Joint Replacement/Heart/Cancer

- Artificial Joint Replacement? If yes, date of replacement Yes No If yes
- Does your doctor or surgeon require you to take antibiotics before dental cleanings and/or treatment? Yes No If yes
- Heart Pacemaker/Defibrillator? If yes, date performed? Yes No If yes
- Have you had cardiac stints placed? If yes, please provide date of placement Yes No If yes
- Do you have an artificial heart valve? If yes, please provide date of placement Yes No If yes
- Cancer? If yes, type and date of diagnosis: Chemotherapy and/or Radiation? Yes No If yes

Allergies

Are you allergic to or have you had an adverse reaction to any of the following?

- No allergies Penicillin Codeine
- Acrylic Metal of any kind Latex or rubber products
- Sulfa Drugs Local Anesthetics/Novocaine, etc. Sulfite/Food additive allergy
- Food Allergies Chemicals or jewelry (rash or sensitivit Aspirin
- Other allergies not listed above? Yes No If yes
- Have you ever had an anaphylactic reaction? Yes No If yes

Health Issues:

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

Bleeding disorder/anemia	<input type="radio"/> Yes <input type="radio"/> No	Blood clots/DVT	<input type="radio"/> Yes <input type="radio"/> No
Blood thinner	<input type="radio"/> Yes <input type="radio"/> No	Blood transfusion	<input type="radio"/> Yes <input type="radio"/> No
Congenital heart disease	<input type="radio"/> Yes <input type="radio"/> No	Chest pain	<input type="radio"/> Yes <input type="radio"/> No
Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Heart disease/Heart attack	<input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Swelling of limbs	<input type="radio"/> Yes <input type="radio"/> No	Asthma	<input type="radio"/> Yes <input type="radio"/> No
Breathing problems	<input type="radio"/> Yes <input type="radio"/> No	Emphysema/COPD	<input type="radio"/> Yes <input type="radio"/> No
Frequent cough	<input type="radio"/> Yes <input type="radio"/> No	Lung disease	<input type="radio"/> Yes <input type="radio"/> No
Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No	ADD/ADHD	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's disease	<input type="radio"/> Yes <input type="radio"/> No	Anxiety/Depression/PTSD	<input type="radio"/> Yes <input type="radio"/> No
Dementia	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No
Fainting spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's disease	<input type="radio"/> Yes <input type="radio"/> No
Substance abuse (Alcohol, Drugs)	<input type="radio"/> Yes <input type="radio"/> No	Acid Reflux	<input type="radio"/> Yes <input type="radio"/> No
Crohn's Disease	<input type="radio"/> Yes <input type="radio"/> No	Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No
Eating disorder	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B, or C	<input type="radio"/> Yes <input type="radio"/> No
Kidney disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Autoimmune disease	<input type="radio"/> Yes <input type="radio"/> No
Fibromyalgia	<input type="radio"/> Yes <input type="radio"/> No	HIV or AIDS	<input type="radio"/> Yes <input type="radio"/> No
Lupus	<input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis	<input type="radio"/> Yes <input type="radio"/> No
Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Scleroderma	<input type="radio"/> Yes <input type="radio"/> No	Sjogren's Syndrome	<input type="radio"/> Yes <input type="radio"/> No
Cataracts	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No
Pain in jaws	<input type="radio"/> Yes <input type="radio"/> No	Sinusitis/Allergy	<input type="radio"/> Yes <input type="radio"/> No
TMJ Disorder	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No		

Other medical issues not listed above?

Yes No

If yes

To the best of my knowledge, the questions on this form have been answered accurately. 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. By signing this form, you agree to be tested for blood-borne infectious diseases in the event of an accidental exposure to our staff, at no cost to the patient.

Signature of Patient, Parent or Guardian: _____

X

Date: _____

Birdwell & Guffey Family Dentistry

(NAME OF PRACTICE)

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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: Vickie Lane
 Telephone: (865) 573-9629 Fax: (865) 577-3966
 Address: 589 E Gov John Serier Hwy Knoxville, TN 37920
 Email: birdwell-guffey@comcast.net

This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S. Department of Health and Human Services rules and regulations.

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Drs. Birdwell and Guffey, D.D.S.

PATIENT PAYMENT OPTIONS

Thank you for choosing our office to help meet your dental needs. Our mission is to deliver the finest, most cost effective health care treatment in a courteous and friendly atmosphere. Following your diagnosis, the doctor will advise you of the treatment plan for your individual needs. Additionally, we will discuss with you the cost of today's treatment and any future treatment.

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

We are sensitive to the fact that some patients may not be able to pay cash for their treatment. Therefore, we do offer several alternative payment methods for your convenience.

- 1) Personal check or cash
- 2) MasterCard, Visa, Discover, and American Express
- 3) Care Credit- this is a separate line of credit for dental care which does not affect the balance of your other credit cards.
- 4) We offer a 5% discount for payment in full with cash or check for treatment over \$500.00.

PATIENTS WITH INSURANCE

We understand the value of insurance benefits and will assist you in obtaining maximum benefit. Please have your insurance information available. We will gladly process your insurance claim and estimate the portion not covered by your insurance. Since insurance is a contract between you and your employer, you are responsible for any balance for services rendered regardless of any insurance you may have.

YOU WILL BE REQUIRED TO PAY YOUR ESTIMATED PORTION AT EACH VISIT.

By doing this, we can greatly reduce the cost associated with sending monthly statements (an expense that must ultimately be added to the cost of dental care). We will be happy to discuss any questions you may have concerning our financial policy or any other aspect of your dental care.

ACCOUNTS OVER 90 DAYS

In the event that the account becomes delinquent, the undersigned agrees to pay all necessary collection fees, attorney fees and court costs.

CANCELLATION/MISSED APPOINTMENT POLICY

We ask that you provide at least 24 hours' notice if you need to cancel or reschedule an appointment. \$40.00 will be charged for a missed appointment or late cancellation. Exceptions can be made for emergency situations.

DIVORCE CASES

In cases of divorce, the individual who receives the care is responsible for payment of any patient balance at the time of service. We will not bill a divorced spouse for the patient's services. The responsibility for the payment of services for minor children belongs to the person who brings the child to the appointment.

Signature of patient or responsible party

Date

CHRIS R. BIRDWELL, D.D.S.

VICKI DAVIS GUFFEY, D.D.S

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FORM

Patient: _____ DOB: _____

Dentist: _____

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2013.

We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

AUTHORIZATION OF PHI DISCLOSURE

The information described above may be disclosed to the following recipients:

Name of Person #1: _____ Relationship: _____

Phone #: _____

Name of Person #2: _____ Relationship: _____

Phone #: _____

I understand that Drs. Birdwell & Guffey will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization form.

In connection with the dental treatment that I receive from the above named dentist, I hereby authorize the above-named dentist to disclose or request any or all information concerning my dental treatment, including copies of any applicable dental records, to and from:

- a. Other healthcare professionals and institutions involved in the delivery of healthcare to me;
- b. The proponent of any legally sufficient subpoena or court order;
- c. Employees and agents of practice, to the degree necessary to facilitate the provision of dental services and payment for such services;
- d. Pharmacies;
- e. Dental laboratories;
- f. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with dentist privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

This consent is valid from the date executed until revoked in writing by the patient:

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

I authorize the office of Drs. Birdwell & Guffey to leave messages by way of:

(Please check all that apply)

() Voicemail/Answering machine _____

() Email: _____

() Text: _____