Dental History

Name: ______________________________ Date:_______________ Weight: ______________

Date of Birth: ________________________ **Please Circle**: Male or Female

What would you like us to do today?________________________ Are you in discomfort? _____Yes _____No

Former Dentist: ____
Address: __________________________________ Phone : ______________________________

Date of last dental care________________________ Last x-rays ______________________________

Check if you've ever experienced any of the following:

____Bad Breath	____Grinding or clenching teeth	____Sensitivity to cold
____Bleeding gums	____ Food collection between teeth	____Sensitivity to hot
____Periodontal treatment	____Clicking or popping jaw	____Sensitivity to sweets
____Sores or growths in mouth	____Loose teeth or broken	____Sensitivity when biting

How often do you brush? ______________________________ Floss? ______________________________

Is there anything you would like to change about the appearance of your teeth? ____Yes ____No
If yes, explain: ____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
_____Yes _____No Explain: ____

Have you ever had orthodontic treatment (e.g. braces, retainer, etc.)? _____ Yes _____No
If yes, when? ____

Other information about your dental health or previous treatment: ______________________________

Medical History

Physician's Name:____ Phone: __________________________

Date of last visit:_______________ Have you ever been hospitalized? ____ Yes ____No
If yes, explain: ____

Are you currently under the care of a physician? _____Yes _____No
If yes, describe:____

List any medications you are currently taking and for what condition they were prescribed:__________________
____

Are you allergic to or have ever reacted adversely to any medication? _____Yes _____No
Please list:
____

Women: Are you pregnant? _____Yes ____ No Nursing? _____Yes _____No Taking birth control? ____Yes ____No

When you walk up stairs or take a walk, do you ever have to stop because of chest pains, shortness of breath, or because you are very tired? _____Yes _____No

Dental History

Check if you have or have ever had any of the following:

___AIDS/HIV Positive
___Alcoholism
___Anaphylaxis
___Anemia
___Arthritis/Rheumatism
___Artificial heart valves
___Artificial joints
___Asthma
___Allergies
___Back problems
___Blood disease
___Cancer
___Chemical dependence
___Chemotherapy
___Circulatory problems
___Cold sores/ fever blisters
___Cortisone treatments
___Cosmetic surgery
___Cough, persistent
___Cough up blood
___Diabetes
___Blood thinners

___Developmentally disabled
___Epilepsy
___Fainting
___Food allergies
___Glaucoma
___Headaches
___Heart murmur
___Heart problems
Explain___________________
____
___Hemophilia/ Abnormal bleeding
___Herpes
___Hepatitis
___High blood pressure
___Jaw pain
___Kidney disease/ malfunction
___Liver disease
___Material allergies (latex, wool, metal, chemicals)
___Mitral valve prolapse
___ Heart surgery

____Nervous problems
____Pace maker
____Psychiatric care
____Rapid weight loss/gain
____Radiation treatment
____Respiratory disease
____Rheumatic/ Scarlet Fever
____Shingles
____Shortness of breath
____Sinus problems
____Skin rash
____Spina Bifida
____Stroke
____Surgical implant
____Swelling of feet/ ankles
____Thyroid disease/ malfunction
____Tobacco habit
____Tonsilitis
____Tuberculosis
____Ulcer/ Colitis
____Venereal disease

Any disease not listed above, please explain: ____
____

I understand this information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

____ ________________
Patient Signature Date

CONSENT:

1. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

____ ________________
Patient or Responsible Party's Signature Date

____ ________________
Witness Date

About Financial Arrangements and Insurance

Again, if you are a participant of one of the following: Blue Cross/Blue Shield of Texas; PPO; Sanus; or any capitated plan, please inform us at the time you sign in.

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive you maximum allowable benefit. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangement have been approved in advance b our authorized staff. We will be happy to help you process you insurance claim for your reimbursement or you may assign you benefits to the doctor as partial payment toward services rendered.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and are therefore covered up to the maximum allowable determined by each carrier. Thus our fees are considered usual, reasonable and customary by most insurance companies. This statement does not apply to companies. This statement does not apply to companies based on the current standard and cost of care in the area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Temporary financial problems may affect timely payment of you account. If such problems arise, we encourage you to contact us promptly for assistance in the management of you account.

If you have questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ASK US. WE ARE HERE TO HELP YOU.

I understand and aggress that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

__________________________________ ________________

Signature Date

PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Date:___________________

NAME:____SS#_____________________
ADDRESS:____
CITY:____________________________STATE:_____________ZIP:_______________
HOME PHONE:________________WORK:_______________CELL:_______________
D.O.B.:________________AGE:_____MARRIED/ SINGLE/ DIVORCED/ WIDOWED
EMPLOYER:_____________________________________POSITION:_______________
HOW WERE YOU REFERRED TO OUR OFFICE?_____________________________
DRIVER'S LICENSE:_________________________________STATE:_______________
E-MAIL:____

RESPONSIBLE PARTY INFORMATION

NAME:____
ADDRESS:____
CITY:__________________________STATE_________________ZIP:______________
HOME PHONE:________________WORK:_______________CELL:________________
EMPLOYER:_____________________________POSITION:______________________
RELATIONSHIP TO PATIENT:____

INSURANCE INFORMATION

INSURED NAME:_____________________DOB_________SS#_____________________
INSURED EMPLOYER:______________________________PHONE:________________
EMPLOYEE ID#:_________________________________GROUP#_________________
INSURANCE CARRIER:____

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future dental condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dental practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that he/she has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, it may be necessary to use this information to obtain approval for treatment prior to performing a procedure.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activity of our dental practice. These activities include, but are not limited to, quality assessment, licensing, and conducting or arranging for other business activities. In addition, we may usea sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when our dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. With your authorization we may use or disclose your protected health care information in the following situations. These situations include: Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity; Military Activity and National Security; Worker's Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made *only with your consent*, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our dentists.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:__________________________________ Signature__________________________________