NORTH GARLAND Familydental

WELCOME!

NORTH GARLAND FAMILY DENTAL

General, Cosmetic, and Implant Dentistry

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient ____Date of Birth _____/______/______

Address ____

City____State______________________Zip______________

I, the undersigned, authorize:

____

to release to, or to obtain my medical records from the following individual:

____

____

My request for this particular release of medical records includes the following specific records (Please include inclusive dates and/or specific type of record):

____

Instructions ____

____

The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature ____Date _____/_____/______

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/13/03, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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 at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment:: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment:: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. 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 your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We must disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using your professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

NOTICE OF PRIVACY PRACTICES (continued)

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address listed at the end of this Notice. If you request copies, we will charge you $0.35 for each page, $12.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to 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.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or has questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or 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.

CONTACT OFFICER: Nancy Henrichsen TELEPHONE: 972-530-7979 FAX: 972-530-6434

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

** You may refuse to sign this acknowledgement. **

I, ________________________________ have received a copy of this office's **"Notice of Privacy Practices."**

____
Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY below this arrow. ____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign.

____ Communication barriers prohibited obtaining the acknowledgement.

____ An emergency situation prevented us from obtaining acknowledgement.

____ Other (Please specify in bottom area:)

How did you hear about us?
Referred by: ______________________ Door Hanger ____
Company Flyer: (Employer) ______________________
Web site: ____ Other (please explain): ______________________

PATIENT REGISTRATION

First Name: ______________________ Last Name: ______________________

Preferred Name: ______________________

Patient is: ☐ Policy Holder ☐ Responsible Party

Responsible Party (if someone other than the patient) ______________________

First Name: ______________________ Last Name: ______________________

Address: ______________________ Address 2: ______________________

City, State. Zip: ______________________ Home Number: ______________________

Work Number: ______________ext:________ Cellular ______________ Pager ______________

DOB: ______________ SSN: ______________ Drivers Lic.: ______________

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information ______________________

Address: ______________________Address 2: ______________________

City: ______________ State / Zip: ______________ Pager: ______________

Home Phone: ______________ Work Phone: ______________ Ext. ________ Cellular: ______________

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single Divorced ○ Separated ○ Widowed

DOB: __________ Age: ______ SSN: ______________ Drivers Lic.: ______________

E-mail: ______________________ ☐ If you would like to receive correspondences via e-mail.

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: ______________Pref. Dentist: ______________

Employer ID: ______________ Pref. Pharmacy: ______________

Carrier ID: ______________ Pref. Hyg.: ______________

Spouse Name:______________

Spouse wk.#: ______________

ER Contact Person: ______________

ER Contact wk #: ______________

ER Contact cell #: ______________

Physician: ______________

Physician #: ______________

—— Primary Insurance Information ——

Name of Insured: ______________ Relationship: __________ DOB: ________ SSN: _____- _____ - ________

Employer: ______________ Address: ______________ City, ST, Zip ______________

Ins. Company ______________ Address: ______________ City, ST, Zip ______________

Dental Insurance Coverage

Kindly supply us with detailed insurance information. We will be happy to assist you with filling your insurance claims. Please note, this Is a courtesy we offer our patients and we cannot be responsible for claims that are denied for any reason.

______________________________ ______/________/____________
Patient Signature (or Parent if patient is a minor) Date

1309 Beltline Rd, Suite A, Garland, TX 75040, M - Thurs, 8 AM - 5 PM, FRI 8 AM - 12 PM, (972) 530-7979

Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please circle your answer:

Are you under a physician's care now? Yes No N/A ____________________

Have you ever been hospitalized or had a major surgery? Yes No (Explain) ____________________

Have you ever had a serious neck or head injury? Yes No (Explain) ____________________

Are you taking any medications, pills, or other drugs? Yes No (Explain) ____________________

Do you take, or have taken, Phen-Fen or Redux? Yes No Are you on a special diet? Yes No

Do you use a controlled substance Yes No Do you use tobacco Yes No

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other ____________________

Do you have, or have you had, any of the following? Check all that apply to your situation.

Blood Disorders:

__ Aids/HIV Positive
__ Anemia
__ Excessive Bleeding
__ Hemophilia
__ Leukemia
__ Sickle Cell Disease
__ Blood Transfusion
__ Bruise Easily

Heart Problems:

__ Angina
__ Chest Pains
__ Heart Attack/Failure
__ Artificial Heart Valve
__ Mitral Valve Prolapse
__ Irregular Heartbeat
__ Heart Pace Maker
__ Heart Murmur
__ Congenital Heart Disorder
__ Rheumatic Fever
__ Scarlet Fever
__ Stroke
__ Fainting Dizzy Spells
__ High Blood Pressure
__ Low Blood Pressure

Tumors/Growths:

__ Cancer
__ Chemotherapy
__ Radiation Treatments

Allergies/Breathing Problems:

__ Asthma
__ Emphysema
__ Frequent Cough
__ Hives/Rash
__ Hay Fever
__ Sinus Trouble
__ Lung Disease
__ Tuberculosis

Bones/Joints:

__ Artificial Joint
__ Arthritis/Gout
__ Rheumatism
__ Swelling of Limbs
__ Cortisone Medicine

Abdominal:

__ Ulcers
__ Kidney Problems
__ Renal Dialysis
__ Liver Disease
__ Hepatitis A B C
__ Yellow Jaundice
__ Hypoglycemia
__ Diabetes
__ Excessive Thirst
__ Frequent Diarrhea

Head/Neck Problems:

__ Thyroid Disease
__ Parathyroid Disease
__ Pain in Jaw Joints

__ Tonsillitis
__ Frequent Headaches
__ Cold Sores/Fever Blisters
__ Convulsions/Seizures
__ Anaphylaxis
__ Epilepsy
__ Glaucoma
__ Spina Bifida
__ Psychiatric Care
__ Alzheimer's Disease
__ Recent Weight Loss
__ Drug Addiction
__ Herpes/Genital Herpes
__ Shingles
__ Venereal Disease

Other: ____________________

Dental History

Chief Oral Complaint/Problem ____________________

____

Are you satisfied with the appearance of your teeth? ○ Yes ○ No Explain: ____________________

Date of Last Dental Visit __________ What was done at that time? ____________________

Former Dentist Name ____________________ City ____________________

Please check all that apply:

__ Teeth sensitive to cold, sweets heat, pressure
__ Bleeding gums, how long? ____
__ Food impaction between teeth
__ Clenching or grinding
__ Burning of Tongue
__ Swelling or lumps in the mouth

Dental History Continued

__ Frequent blisters on lips or mouth	__ Bad breath	__ Unfavorable dental experience	__ Orthodontics (Braces)
__ Pain around ear - - TM disorders	__ Do you gag easily	__ Complications from extractions	__ Mouth Breathing
__ Unusual sounds around ear - - TMJ, clicking or popping	__ Unpleasant taste	__ Periodontal treatment (gums)	__ Oral habits (fingernail biting etc)

Have you ever used NO^2 or laughing gas for dental treatment? ○ Yes ○ No **Were there complications?**__________________

__ Cigarettes, cigar, pipe smoking, smokeless tobacco - - **Frequency**________________

Texture of tooth brush _________________________ **Frequency of brushing** _____________________________________/Day

Do you use?

__ Dental Floss

__ Inter Dental Stimulators

__ Water jet device

__ Disclosing tablets or solution

__ Fluoride supplements

__ Mouthwash

Comments:____

____

____

To the best of my knowledge, the questions on this form have been accurately answered. 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.

____ ________________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

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