

PATIENT INFORMATION AND HEALTH HISTORY

Patient's Name _____ Date of Birth _____

Responsible Party _____ Relationship to Patient _____

Home Address _____ City _____ Zip _____

Home Phone _____ Social Security _____ TX Driver's License # _____

Employed by _____ How Long _____ Email Address _____

Business Address _____ City _____ Zip _____

Business Phone _____ Cell Phone _____

Dental Insurance Plan _____ Group _____

Spouse's Name _____

Spouse's Employer _____ How Long _____

Business Address _____ City _____ Zip _____

Business Phone _____ Dental Insurance Plan _____

Group # _____ Spouse's Social Security # _____

Name of Nearest Relative not living with you _____

Address _____ City _____ State _____ Zip _____

Phone _____

Referred to this office by _____

DENTAL HISTORY

Chief Oral Complaint _____

Date of Last Dental Exam _____

What was done at your last exam? _____

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

- _____ Tooth sensitivity _____ Bad Breath _____ Periodontal Treatment
- _____ Bleeding Gums _____ Unpleasant Taste _____ Swelling or Lumps in mouth

MEDICAL HISTORY

- _____ Mouth breathing _____ Complications from extractions _____ Cigarette, pipe or cigar smoking
- _____ Clenching or grinding _____ Pain around ear or jaw joint _____ Burning tongue

Are you dissatisfied with the way your teeth look? _____

Please list any medications you are taking _____

Physician's Name _____ Phone _____ Last physical exam _____

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

- _____ Drug allergies _____ Kidney problems _____ Neurological problems
- _____ Heart or lung ailments _____ Stomach disorders _____ Stroke
- _____ Abnormal blood pressure _____ Thyroid problems _____ Arthritis
- _____ Excessive bleeding _____ Radiation treatment _____ Malignancies
- _____ Rheumatic fever _____ Sinus problems _____ Tonsillitis
- _____ Hepatitis _____ Asthma, hay fever _____ Tuberculosis
- _____ Diabetes _____ Anemia _____ Venereal Disease

WOMEN: Are you pregnant? _____ If so, what month is the baby due? _____

Do you have any other health condition such as heart condition or joint replacement which would require premeditation?

Signature _____ Date _____

My Dentist

Gerald W. McDougal DDS

512.454.5219

8015 Shoal Creek #108

Austin, Tx. 78757

Directions to Office

Our office is located one block east of Mopac Blvd on Shoal Creek Blvd, between Anderson Ln and Steck Ave in a red/brown brick business center, across the street from Lowes.

We ask for 24hr notice if you need to cancel your appointment. This notice will allow us to fill the open spot with a patient in need of an appointment.

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.**

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.

- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

<p>Please contact us for more information:</p> <p>Gerald W. McDougal, D.D.S., Inc. 8015 Shoal Creek Blvd Ste 108 Austin, TX 78757 512-454-5219</p>	<p>For more information about HIPAA or to file a complaint:</p> <p>The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775</p>
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Notice of Privacy Practices Acknowledgement

Gerald W. McDougal, D.D.S.
8015 Shoal Creek Blvd Ste108
Austin, TX 78757

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

INFORMATION TO PATIENTS REGARDING YOUR DENTAL INSURANCE

PROOF OF INSURANCE IS REQUIRED.

1. You are responsible to us for full payment of all fees incurred by you.
2. We will file your insurance for you, it is ultimately **your responsibility** to make sure it has been filed and processed correctly with **your** insurance company. We cannot possibly keep track of every insurance claim we file. Failure to file a claim will result in nonpayment. **You must assist us in the process.**
3. We do not know exactly what your insurance company will pay towards your dental care. We can estimate, by calling **YOUR** insurance company, but we do not know.
4. As a courtesy to you, payment of what we **THINK** is your portion is due at the time of service.
5. **NOTE:** If your insurance company does not pay what you/we **EXPECT** them to pay within 90 days, you must pay the balance due in full.
You can then work with your insurance company to collect from them.
6. **If your balance is not paid within 90 days from the date of service a statement charge of \$5.00 and finance charges will be added. In the event a legal suit or outside collections are necessary to enforce payment of the account, the patient agrees to pay for all collection fees and/or attorney's fees and court costs as may be deemed reasonable.**

Signature: _____

Date: _____

Your insurance company is responsible to you.

We do not work for your insurance company.

Many dentists will not even file an insurance form for the patient. They require payment **in full** at the time of service. They give the patient a statement of the services rendered and have the patient file with their insurance company.

HAVE THE PATIENT SIGN THIS FORM AND GIVE A SIGNED COPY TO THE PATIENT.