

Date _____

Patient's Name _____ Social Security # _____

Date of Birth _____ Age _____ Marital Status _____

If child, guardian's name _____ Social Security # _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____

Email _____

Employer _____ Occupation _____ Work Phone _____

Spouse Name _____ Employer _____ Work Phone _____

Emergency Contact (not living at your address) _____ Phone _____

How did you hear about our office? _____ Purpose of Visit _____

Who will pay this account? _____ Payment: Cash _____ Check _____ Visa/MC _____

Dental Insurance company _____ Policy Number _____

Is there anything about the appearance of your teeth that you don't like?
 Color, shape, size, spaces, cracks, chips, alignment, other _____

MEDICAL HISTORY

Please check any of the following which apply to you now or in the past, if *none* apply, please check here .

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart Ailment | <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Prosthetic Joint | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes/Type: _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer/Date: _____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> High Blood Pressure: ____/____ |
| <input type="checkbox"/> Allergy to Mercury, Nickel or Other Metals | <input type="checkbox"/> Other: _____ | | |

Do you have or have had:

- | | | |
|--------------------------|--------------------------|----------------------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Health Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding from a Cut |
| <input type="checkbox"/> | <input type="checkbox"/> | ...or a Tooth Extraction |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment to Head/Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Women: Are you Pregnant |

Do you have allergies or reactions to:

- | | | |
|--------------------------|--------------------------|----------------------|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetic |
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin or Ibuprofen |
| <input type="checkbox"/> | <input type="checkbox"/> | Any Other Drugs: |

Has a physician ever informed you of a physical condition requiring antibiotics prior to having dental work or teeth cleaning?

Yes _____ No _____ Name of Antibiotic _____

Are you under the care of a physician now? Yes _____ No _____

Name of Physician _____ Phone _____

Are you currently taking any drugs or medications? Please List: _____

Other physical conditions? _____

Patient/Guardian Signature _____ Date: _____

Updated/Initial: _____

Patient Name _____ Date _____

- | | | | | |
|---|-------|--------------------------|----|--------------------------|
| 1. Do your gums bleed? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Do you feel you have bad breath? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Do you wish your teeth were whiter? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Do you like the way your teeth are shaped? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. Are you pleased with the appearance of your smile? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. Are you interested in cosmetic dentistry? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7. Are you interested in INVISALIGN? (clear, removable braces) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 8. What part of dentistry or going to the dentist would you most like to change if you could? | _____ | | | |

9. On a scale from 1 – 10, how important is it for you to keep your teeth for a lifetime? (10 being very important) _____

10. On a scale from 1 – 10, how would you rate your apprehension with dental visits? (10 being very nervous) _____

11. Why did you leave your last dentist? _____

**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.

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 April 1, 2003, 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 policy 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 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 listed 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 or disclose your health information to obtain payment for services we provide 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 the 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 you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose 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, of 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 our 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.

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 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 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).

PATIENTS 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 practicably 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 at the end of this notice. If you request copies, we will charge you \$.50 for each page and \$15 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 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. (Your request must be in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation 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 have 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 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: **Jeffrey S. Lide, D.D.S.**

Address: **330 Municipal Drive, Suite 100, Richardson, TX 75080**

Telephone: **972.479.0477**

FINANCIAL POLICY

We are committed to providing you with the best possible care. Please understand that payment of your bill is considered your responsibility. The following is a statement of our FINANCIAL POLICY that we require you to read, agree and sign prior to any treatment. For your convenience we accept cash, checks, MasterCard, and Visa as forms of payment.

CANCELLATION POLICY

Our office has a CANCELLATION POLICY, **which requests a 48 business hour notification**, but a **\$75 charge will apply** due to a late cancellation or a missed office visit **if we do not receive notification of at least 24 hours.**

Please initial _____

INSURANCE

As a courtesy to you, we file your insurance claim; however, you must provide all insurance information to our office prior or at time of service. Should you elect to file your own insurance claim, you will be expected to pay for all charges at the time of service. Please understand that your insurance policy is a contract between you and your insurance company. We are NOT part of that contract and benefits are not determined by our office. If we are a Preferred Provider (in-network) for your insurance, our agreement is to abide by the specified fee schedule. We cannot control downgrades (alternative benefits) and the combining of certain procedures by your insurance company-that results in a lesser payment. If we are not a Preferred Provider (out-of-network) for your insurance, you are responsible for paying the bill in full, regardless of what fees your insurance company determines is usual and customary. Our practice is committed to providing the best possible treatment and we charge fees that are usual and customary for our area. In conclusion, any balance is your responsibility **whether your insurance company pays expected benefits or not.**

SELF PAY

Payment in full is due at the time of service. If financial arrangements are necessary, we have options through an outside program that is available, please ask our Office Manager for information.

DELINQUENT ACCOUNTS

Accounts that are not paid in full or satisfactory arrangements not made within 60 days of service rendered are considered delinquent; these accounts will be turned over to a collection agency and reported to a nationwide credit bureau. Please let us know if you have any questions or concerns.

I have read, understand and agree to the above Financial Policy.

Patient /Responsible Party

Date