HUDSONOAKS
FAMILY DENTISTRY

PATIENT INFORMATION

(All Fields Required if * is Presented)

PERSONAL

*Patient Name: _____
Last First MI (Preferred Name)

Birthdate: _____ SSN: (we use this for insurance & financial purposes): _____ DL: _____

Gender: ◯ M ◯ F Married: ◯ Y ◯ N

Work Phone: _____ *Cell Phone: _____ *Email: _____

If patient is under 18 years, please also complete the following:

*Guarantor Name: _____

*Birthdate: _____ SS#: _____ DL#: _____ Gender: ◯ M ◯ F Married: ◯ Y ◯ N

Work Phone: _____ *Cell Phone: _____*Email: _____

Student status if dependent over 19 (for ins) ◯ Nonstudent ◯ Fulltime ◯ Part time

How did you hear about us? (Please be specific so we can thank them!) _____

_____

ADDRESS AND HOME PHONE

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Home Phone: _____ Check circle if same for entire family: ◯

INSURANCE POLICY

Note: If we already have your insurance info, you do not have to fill this part out.

*Patient relationship to subscriber: ◯ Self ◯ Spouse ◯ Child

*Subscriber Name: _____ *Sub.ID #: _____ *Sub DOB: _____

*Insurance Company: _____ *Phone: _____

*Employer: _____ Group Name: _____ *Group #: _____

FINANCIAL AGREEMENT

- For my convenience, this office may release my information to my insurance, and receive payment directly from them.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- Treatment plans may change, and I will be responsible for the work done.

*Signature: _____ *Date: _____

MEDICAL HISTORY

Name of Medical Doctor: _____ City/State: _____

*Emergency Contact: _____ *Phone: _____ *Relationship: _____

*List all the medications or drugs you are now taking, or provide a medication list to the office staff.

◯ None

_____

_____

_____

_____

*Check medications or drugs you are allergic to including the following, but not limited to or NONE.

◯ None
◯ Aspirin
◯ Codeine/ Other Narcotics
◯ Erythromycin
◯ Latex Rubber
◯ Local Anesthetics
◯ Metals
◯ Penicillin
◯ Sulfa Drugs
◯ Other: _____

*Check any medical conditions you may have or NONE:

◯ None
◯ AIDS
◯ Alcohol/Drug Abuse
◯ Anemia/Leukemia
◯ Anorexia/Bulimia
◯ Arthritis
◯ Asthma/Hay Fever
◯ Blood Clotting Problems
◯ Blood Transfusion
◯ Bronchitis
◯ Cancer/Tumor or Growth
◯ Cardiac Pacemaker
◯ Chest Pain Upon Exertion
◯ Damage Heart Valve
◯ Osteoporosis
◯ Diabetes
◯ Emphysema
◯ Epilepsy
◯ Fainting Spells/Seizures
◯ Fever Blisters/Herpes
◯ Frequent Headaches
◯ Frequently Dry Mouth/Sjogren
◯ Gall Bladder Trouble
◯ Heart Attack/Stroke
◯ Heart Disease/Angina
◯ Heart Murmur
◯ Hepatitis/Jaundice
◯ High Blood Pressure
◯ Hives/Skin Rash
◯ HIV
◯ Joint Replacement, Date of: _____
◯ Kidney/Bladder Trouble
◯ Liver Disease
◯ Low Blood Pressure
◯ Mental Health Problems
◯ Mitral Valve Prolapse
◯ Persistent Diarrhea
◯ Rheumatic Fever
◯ Rheumatic Heart Disease
◯ Sexually Transmitted Disease
Specify: _____
◯ Sinus Trouble
◯ Stomach Ulcers
◯ Thyroid Problems
◯ Tuberculosis

Have you ever taken or are currently taking Fosamax, Bisphosphonates or Prolia? ◯ Y ◯ N

Women only- Are you pregnant or do you have reason to believe you may be? ◯ Y ◯ N

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? ◯ Y ◯ N

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

By signing below, I certify that all the above information is true to the best of my knowledge.

_____ _____

*Patient/Guardian Name (printed) *Date

_____ _____

*Patient/Guardian Signature *Date

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. The privacy of your health 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 (10/13/03) 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 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. A down-payment or payment in full is REQUIRED prior to scheduling treatment. As this is a set amount of time the Dr is blocked off from seeing other patients. Please see appointment reminders section for a detailed explanation of our appointment confirmation/reminder expectations

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 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 official's 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.

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 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 $2.00 for each page, $15.00 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 alterative locations. {You must make your request 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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 alterative 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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

*Patient/Guardian Name (printed) *Date

_____ _____

*Patient/Guardian Name (signature) *Date

Appointment Reminders and Confirmation Policy:

We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, text messages, emails, or letters). Appointment confirmations are REQUIRED to keep appointment date and time. A $50 cancelation may apply to confirmed no-show appointments. If appointments are not confirmed within 2 business days of appointment date, it will be subject to removal from the schedule. If appointments need to be change or cancelled a 2 business days' notice is REQUIRED or a $50 fee WILL apply.

_____ _____

*Patient/Guardian Name (printed) *Date

_____ _____

*Patient/Guardian Name (signature) *Date

Please note that if you would like a copy of our HIPPA/Privacy Policy, a paper copy will be available behind this paperwork. If one is not present and you would like a physical copy, please ask a staff member and we be more then happy to assist you.

For Office Use Only

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 prevented us from obtaining acknowledgement.
- Other (Please Specify)

Permission to use photographs – Hudson Oaks Family Dentistry

This section is not required unless, you want us to use your picture for our social media.

I, _____grant Hudson Oaks Family Dentistry the right to take photographs of me and my family. Hudson Oaks Family Dentistry may use such photographs with or without my name for lawful purposes, including clinical chart reviews, communication with dental laboratories, communication with other dental specialists and professionals, illustrations, advertising, and web content.

Should I wish to send these photographs to other dental care providers, I shall formally request them in writing as is required by the State Dental Board of Texas for a transfer of records.

I have read and understand the above:

_____ _____

*Patient/Guardian Name (printed) *Date

_____ _____

*Patient/Guardian Name (signature) *Date