DENTISTRY & ORTHODONTICS
Creating Beautiful Smiles

NEW PATIENT INFORMATION

Patient Last Name: _____ First Name:_____ Middle Initial:_____

Patient Address:_____City:_____ State:_____ Zip Code:_____

Birth Date:_____ Age:_____ Social Security # _____ Drivers Lic # _____

Male / Female Marital Status: _____ Hm Ph #:_____ Cell Ph #: _____

Patient Employer:_____

E-Mail Address: _____

Spouse's Name: _____ If child Mothers Name:_____ Fathers Name:_____

Nearest Relative other than Spouse: _____ Phone #:_____

ACCOUNT INFORMATION

How do you intend to pay for your Dental Services? _____

Dental Insurance – Company Name:_____ Policy# _____ Group #_____

Policy Owner Last Name:_____ First Name:_____

Date of Birth:_____ Social Security #_____ Drivers LIC # _____

Policy Owner's Employer:_____

Who may we thank for referring you to our office? _____

When was your last dental visit? _____

How do you feel about the appearance of your smile: _____Teeth Shade: _____ Teeth Alignment: _____

Please share with us your fears and concerns: pain, expense, time or other _____

9950 Woodlands Parkway, Suite 500
The Woodlands TX 77382
Tel: (281)292-1220 Fax: (281)292-2822

100 Medical Center BLVD
Conroe, TX 77304
Tel: (936) 441-7300 Fax: (936) 760-4439

www.dentistry-orthodontics.com

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Name: _____ Date of Birth: _____

Health History Form

E-mail: Today's Date:

Name: _____ Date of Birth: _____ Phone Number: _____

Do you have any of the following diseases or problems:	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information *Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone:			
Address/City/State/Zip:			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the last year?	☐	☐	☐
If yes, what condition is being treated?			
Date of last physical exam:			
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic Total joint (hip, knee, elbow, finger)replacement?	☐	☐	☐
Date: _____If yes, any complications? _____			
Are you taking or scheduled to begin taking either of the Medications, alendronate (Fosomax) or risedronate (Actonel) For osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (aredia or someta) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem? _____			
Are you taking or have you recently taken any prescriptions Or over the counter medicine	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: _____			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? Very/Somewhat/Not			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24hrs? _____			
If yes, how much do you drink typically in a week?_____			
WOMEN ONLY: Are you Pregnant?	☐	☐	☐
Number of weeks: _____			
Birth control pills or hormonal replacement	☐	☐	☐
Nursing	☐	☐	☐

Allergies – Are you allergic to or have you had a reaction to: To all **yes** response, specify type of reaction.	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐

Allergies (Continued):	Yes	No	DK
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems:

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐

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Medical Information

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problem.

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapsed	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐

	Yes	No	DK
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcer	☐	☐	☐
Thyroid problem	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Blood transfusion	☐	☐	☐

If yes, date: _____

	Yes	No	DK
Mental health disorder	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infections: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: _____Phone: _____

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐

Please explain:

Dental Information

For the following questions, please mark (x) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: Daily / Weekly / Occasionally			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pain?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you have brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam: _____

What was done at that time? _____

_____

Date of last dental x-rays: _____

What is the reason for your dental visit today?_____

How do you feel about your smile?

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patients health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print Name

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Consent For Use and Disclosure of Health Information

Section A: Patient giving consent

Name: _____

Phone Number: _____ Email: _____

Section B: To the Patient- Please read the following statements CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice MAY BE GIVEN UPON REQUEST. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time

Right to Revoke: You will have the right to revoke this Consent at any time by submitting to us a written notice of your revocation to the Contact Person listed above.
Please understand that revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy
Practices. I understand that, by signing this Consent form, treatment, payment activities and healthcare operations.

Signature: _____ Date:_____

If the consent is signed by a personal representative on behalf of the patient, complete the following:

Legal Guardian's Name: _____

Relationship to the Patient: _____

Name: _____ Date of Birth: _____

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 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 (October 2009) and will remain in effect until we replace it.

We reserve that right to change our privacy practices and the terms of the 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 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 the Notice, please contact us using the information at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment and health care operations. For example:

TREATMENT: We may use and 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 provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improved activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner 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 authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us 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 with your consent.

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, location, 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 and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences regarding your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or to her 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 institutions or law enforcement officials 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 obtain 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 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 the Notice. If you request copies we will charge you .10 for each page, $5 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 you health information for a fee. Please contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosing 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 October 2009. 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 those additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use of 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 Communications: 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 how payment 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 circumstance.

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

QUESTIONS AND COMPLAINTS

f 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 alternative locations, you may communicate to us using the contact information listed below. You may also submit a written complaint to the US 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 of with the U.S department of Health and Human Services.

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Patient Financial Policy

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy. If you have any questions about our policies and/or your responsibilities simply ask one of our friendly and knowledgeable team members. We are here to assist you.

Payment Options: We accept cash, checks, Visa, Mastercard, American Express and Discover. We also accept the Care Credit payment options.

Insurance: As a courtesy to our patients and at your request, we will be happy to file your claim with the Insurance Company based on the information that you have provided to our office... Please be aware that verification of benefits and filing of a claim **DOES NOT GUARANTEE PAYMENT**. The determination of whether the claim is paid is made by the Insurance Company when they receive the claim. **At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance policy**. Because of insurance policy changes and/or necessary changes in treatment plans, your dental coverage **may** vary from this estimated treatment calculation or your carrier's pre-estimate.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. Our office will submit your claim to your insurance company twice if necessary. Additional submissions are the patient's responsibility. If your insurance company has not paid the full balance of the claim within 60 days from the treatment date, you will be responsible for the balance.

Missed Appointments: Once an appointment has been made, please remember that this time has been specifically reserved for you. No charge will be made for rescheduling an appointment provided 24 hours notice is given. We reserve the right to assess a $75.00 per half –hour fee for any appointment that is missed without a courtesy call to reschedule. The missed appointment fee is not a covered expense of your insurance company.

Returned Checks: A $35.00 fee will be assessed for any check returned for insufficient funds.

Accounts: A late fee of $35.00 may be assessed to accounts with balances outstanding for 60 days from treatment date. In the event of non-payment, the patient or responsible party agrees to pay all the costs of collection including but not limited to attorney fees, court costs, collection agency fees etc.

I have read, understand, and agree with all the terms and conditions of this Patient Financial Policy. By signing below I authorize the insurance company to pay Dentistry & Orthodontics all insurance benefits otherwise payable to me for services rendered. I authorize Dentistry & Orthodontics to release all information necessary to secure payment for benefits. I understand that I am financially responsible for all charges.

Signature of Patient/Parent/Guardian_____Date_____

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