Date________________

How did you hear about us? ____

PATIENT INFORMATION

Patient Name ________________________________ Preferred Name ______________

Address ________________________ City/State ______________ Zip Code __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ______________________ Best time of day and which phone # to reach you __________

Important Note: **(We use the cell phone number and email address to remind patients of future appointments)**

Sex Female/Male Age ______ Birthdate ________ Marital Status __________ SSN ______________

Employer ____________________________ Occupation ______________________

Employer Address ______________________ Employer Phone ______________

Spouse Name ______________________ Birthdate ____________ SSN ______________

GUARDIAN INFORMATION (if applicable)

Name ____________________________

Address ________________________ City/State ______________ Zip Code __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email Address ______________________ Best time of day and which phone # to reach you __________

Birthdate ______________ SSN ______________

Employer ____________________________ Occupation ______________________

Employer Address ______________________ Employer Phone ______________

Who is responsible for this account? ____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company ______________________

Name of Primary Policy Holder ______________________ Birthdate ______________

SSN ______________________ Relationship to the patient ______________

Policy # ______________________ Group # ______________

Union or Local # ______________________ Anniversary Date of Policy ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________ ______________________ ______________

Responsible Party Signature Relationship Date

EMERGENCY INFORMATION

Who may we contact in case of an emergency? ______________________ Relationship ______________

Phone # ______________ Cell # ______________ Pharmacy phone # ______________

Patient Name ______________________________

Birthdate ______________________________

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ____________
Address ______________________________ City __________ State __________ Zip Code ____________
Have you been under the care of a medical doctor during the past two years?______________________________ Y N
If yes, for what? ______________________________

Please check yes or no to indicate if you have had any of the following:

AIDS / HIV positive	Y N	Emphysema	Y N	Pacemaker	Y N
Alcoholism/Drug Abuse	Y N	Epilepsy or Seizures	Y N	Psychological Problems	Y N
Anemia	Y N	Fainting or Dizzy Spells	Y N	Psychiatric Care	Y N
Arthritis, Rheumatism	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Artificial Heart Valves	Y N	Hay Fever	Y N	Respiratory Disease	Y N
Asthma	Y N	Headaches	Y N	Rheumatic Fever	Y N
Back Problems	Y N	Heart Murmur	Y N	Scarlet Fever	Y N
Bleeding Abnormally	Y N	Heart Problems	Y N	Shortness of Breath	Y N
Blood Disease	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N
Blood Transfusion	Y N	Hepatitis Type ____________	Y N	Sinus Trouble	Y N
Cancer	Y N	Herpes	Y N	Skin Rash	Y N
Chemical Dependency	Y N	High Blood Pressure	Y N	Stomach Disorder (Ulcers)	Y N
Chemotherapy	Y N	High Cholesterol	Y N	Stroke	Y N
Circulatory Problems	Y N	Jaundice	Y N	Swelling of Feet or Ankles	Y N
Congenital Heart	Y N	Jaw Pain	Y N	Swollen Neck Glands	Y N
Contact Lenses	Y N	Joint Replacement When / Type________	Y N	Thyroid Problems	Y N
Cortisone Treatments	Y N	Kidney Disease	Y N	Tonsillitis	Y N
Cough, Persistent/Bloody	Y N	Liver Disease	Y N	Tuberculosis	Y N
Cysts/Tumors Where__________	Y N	Low Blood Pressure	Y N	Tumor or Growth on Head or Neck	Y N
Diabetes	Y N	Mitral Valve Prolapse	Y N	Ulcer	Y N
Diet (Restricted / Special)	Y N	Neurological Disorders	Y N	Venereal Disease	Y N
Eating Disorders	Y N	Nervous or Anxiety Problems	Y N	Weight Loss or Gain, Unexplained	Y N

Allergies [ ] NONE [ ] Amoxicillin [ ] Aspirin [ ] Barbiturates [ ] Codeine [ ] Epinephrine [ ] Erythromycin [ ] Keflex
[ ] Iodine [ ] Latex [ ] Lortab [ ] Morphine [ ] Penicillin [ ] Sulfa [ ] Tetracycline [ ] Other __________

List medications currently taking (name and dosage) ______________________________

____

Do you have or have you had any disease, condition or problem not listed above? Y N
If yes, please explain: ______________________________
Do you need to take any antibiotics (pre-medicate) before any dental appointment? Y N
Have you been in the hospital or had a serious illness within the past five years? Y N
If yes, Please explain: ______________________________
Women: Are you pregnant? Y N Due date____________ Are you nursing? Y N Do you take Birth Control Pills? Y N

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Parent / Guardian Signature X ______________________________ Date ______________
Doctor Signature ______________________________ Date ______________

2212 Central Dr, #101, Bedford, TX 76021
Tel: (817)464-8655 Fax: (817)720-9902

Patient Name ______________________________

Birthdate ______________________________

DENTAL HISTORY

Reason for today's visit ______________________________

Former Dentist ____________________ Phone # ______________ City/State ______________

Date of Last Dental Visit ____________________ Date of last dental X-Rays ____________________

Date of Last Dental Cleaning ____________________

How often do you brush your teeth? ______________ How often do you floss? ______________

What other dental aids do you use? Manual Toothbrush ________ Soft ________ Medium ________ Hard

_______ Toothpick _______ Fluoride Rinse _______ Electric Toothbrush Other ______________

Have you received any formal oral hygiene instruction? Y / N How long ago? ______________

Do you like your smile? Y / N

How do you feel about the appearance of your teeth? ______________________________

What do you wish could be changed? ______________________________

Are you interested in straightening your teeth (Orthodontic treatment)? Y / N Have you had braces before? Y / N

Please circle YES or NO to indicate if you have had or currently have any of the following:

Cold Sores or growths in mouth	Y N	Sensitivity when biting	Y N	Pain around ear	Y N
Sore or Bleeding gums	Y N	Sensitivity with sweets	Y N	Change/Shift in your bite	Y N
Blisters on lips or mouth	Y N	Sensitivity to cold	Y N	Experience pain in jaw joint	Y N
Burning sensation on tongue	Y N	Sensitivity to heat	Y N	Grinding teeth	Y N
Swollen Gums	Y N	Hold foreign objects with your teeth	Y N	Clenching teeth	Y N
Dry Mouth	Y N	Chew on one side of mouth	Y N	Chewing tobacco	Y N
Bad Breath	Y N	Fingernail biting	Y N	Smoke (circle) Cigarette, pipe, cigar	Y N
Mouth breathing	Y N	Lip or cheek biting	Y N	Difficulty with any dental work	Y N
Loose teeth	Y N	Clicking or Popping of the jaw	Y N	Problems getting numb	Y N
Broken fillings	Y N	Difficult in opening or closing mouth	Y N	Wear a bite plate or mouthguard	Y N
Frequent headaches	Y N	Tired jaws, especially in the morning	Y N	Excessive stress or pressure	Y N

A serious injury to the mouth or head Y N Please describe including the cause ______________

Food collection between teeth Y N Please indicate location ______________

Oral Surgery (Extractions) Y N

Endodontic Treatment (Root Canals) Y N

Periodontal Treatment (Gums- Deep Cleaning) Y N If yes: please indicate:

- Osseous Surgery Date ______________
- Tissue Gingival Grafts Date ______________
- Tissue Management (Scaling, Curetage) Date ______________

Do you feel nervous about having dental treatment? Y N

Have you ever had an upsetting dental experience? Y N

Is there anything else about having dental treatment that you would like us to know? Y N

If yes to any of the above, please describe ______________________________

____

____

2212 Central Dr, #101, Bedford, TX 76021
Tel: (817)464-8655 Fax: (817)720-9902

Patient Name ______________________________

Birthdate ______________________________

CONSENT FOR SERVICES, APPOINTMENT AND PAYMENT POLICIES

Meadow Park Family Dentistry is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

Broken or cancelled appointments
If you need to cancel an appointment, please notify us at least 24 hours in advance. We charge $25.00 for each canceled or broken appointment if you do not give us the required advance notice. Please notify us if an emergency makes it impossible for you to give 24 hours notice so we can discuss this with you.

Office Surveillance
Please be advised that all activities within the office are under continuous audio and visual surveillance and recording. We adhere to all HIPAA guidelines as related to these recordings and all office records.

Payment is due at the time of treatment
Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. If we are filing an insurance claim for you, please read the next section for an explanation of payment arrangements. However, payment is due at the time of service for the Initial Emergency or Limited appointments.

Insurance Claims
If we file an insurance claim for you, you will need to pay us at the time of treatment the expected estimated insurance deductible and any estimated amount that we expect insurance will not cover.

We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits.

Your Right - Copy and/or Transfer of your Records
You have the right to inspect and copy your health information and related records, by filling out our release authorization form, records will be sent within 10 days of the receipt of your written request and receipt of the administrative fee. For providing an electronic or paper copy of your health information, we will charge you an administrative fee in responding to your request.

Returned checks
Please take every precaution to avoid giving us a bad check. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments
Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account interest at the rate of 1.5% per month (18% annually) for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

Collection costs
We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

Minors MUST ALWAYS be accompanied by an adult; the adult accompanying a minor will be responsible for payment of services on their appointment. If parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims. I agree to the above policies and charges.

X____ Date ______________

Signature of patient or responsible person

Name of patient ____

Name of person responsible for patient charges, if different ______________________________

2212 Central Dr, #101, Bedford, TX 76021

Tel: (817)464-8655 Fax: (817)720-9902

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

____ Signature of Patient or Legal Representative

________________________ Date

____ Printed Name of Patient

________________________ Legal Relationship to the Patient (*If required*)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name ______________________________ Relationship ______________ Phone____________

2. Name ______________________________ Relationship ______________ Phone____________

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is ________________________________. Please initial _______.

The email address that I authorize to receive email messages for appointment reminders and general health information is ________________________________. Please initial _______.

Or

_________ **I decline** to receive communications via **text**.

I decline to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature____ Date requested: ______________

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on **1/6/2020** and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer – **Durga Buchupally, DDS.** Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $____for each page and the staff time charged will be $______per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include diagnosis, nature of services and treatment. If you have elected to opt out, we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $_____ per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure. May 23, 2016 OCR clarified a flat fee for **electronic copies may not exceed $6.50** (including labor for copies, supplies and postage); this does not mean that the ceiling for all requests for access is $6.50.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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. **HOW TO CONTACT US:**

Practice Name: **Meadow Park Family Dentistry**

Privacy Officer: **Dr. Buchupally**

Telephone: **817-464-8655**

Address: **2212 Central Drive, #101 Bedford, TX 76021**