Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Sex: ___ F ___M Birth Date: _____ Soc Sec: _____-_____-_____
Cell Phone: (___) _____-_____ Home: (___) _____-_____ Work: (___) _____-_____
E-Mail: _____ ___Married ___ Single ___Minor
Employer Name: _____ Full Time____ Part Time ____ Retired____
School Name: _____ Full Time____ Part Time ____

Emergency Contact: _____ Phone #: _____

HOW DID YOU HEAR ABOUT US? _____

May we send you correspondence via email? Y / N
May we send you appointment reminders via text to your cell number? Y / N
(If yes, who is your mobile carrier? _____)
Best time to contact you is: _____ a.m / p.m

Responsible Party (patient is a minor or insurance policy holder)

Name: _____
Relationship to Patient: _____ Phone #: (___) _____
Address: _____ City: _____ State: _____ Zip Code: _____
Birth Date: _____ Soc Sec: _____-_____-_____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____ Birth Date: _____
Insurance Company: _____Member ID: _____
Group #:_____ Employer Name: _____

Do You Have Additional Dental Insurance? ___Y ___N

If Yes, Complete The Following:

Name of Insured: _____ Relationship to Patient: _____ Birth Date: _____
Insurance Company: _____Member ID: _____
Group #:_____ Employer Name: _____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Park Dental Clinic

CONSENT FOR USE AND DISCLOSURE IF HEALTH INFORMATION

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 out 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 is available upon request.

We reserve the right to change our privacy practice 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 by contacting the Privacy Officer at our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer at our office. Please understand that revocation of this Consent will *not* affect any action we took in reliance in this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNITURE - 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, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____

Patient (Guardian) Name

_____ _____

Patient (Guardian) signature **Date**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Website.

Our goal is to provide quality dental care in a timely manner. In order to do so we have had to implement a cancellation and no show policy. The policy enables us to better utilize available appointment for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT: In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you make an attempt to call **24 hours** in advance.

NO SHOW POLICY: A "no show" is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of **$25** for every half hour scheduled.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complaint to us or the U.S Department of Human Services, Office of Civil Rights.
Region VI- Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Ralph Rouse, Regional Manager
Office for Civil Rights
U.S Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, TX 75202
Voice Phone (214)767-4056, FAX (214)767-0432, TYDD (214)767-8940

We will not retaliate against you if you make a complaint. If you want to complaint to us, send a written complain to the office contact person at the address of 771 W. Round Grove Rd #W100 Lewisville, Texas 75067, FAX (469)619-0310 or via e-mail at parkdentaltexas@gmail.com. If you prefer, you can discuss your complaint in person or phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number listed above in this notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Park's Notice of Privacy Practices.

_____

Patient (Guardian) Name

_____ _____

Patient (Guardian) signature **Date**

Financial Policy

We ask that all patients read and sign our financial policy as well complete our patient information form prior to seeing the dentist. Payments of services are due at the time services are rendered. We accept cash, credit, check and care credit. We may accept assignments of insurance benefits. However, you must understand that:

*Your insurance policy is a contract between you, your employer and the insurance company. We are not a party of that contract! Our relationship is with you, not your insurance company. Our involvement will be limited to supplying factual information to facilitate claim processing.

*__All charges are your responsibility whether your insurance company pays or does not pay.__ Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

*Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.

*I understand that the employees of Park Dental Clinic and associates are not representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company. Estimates are only good for 30 days.

*If your insurance does not pay within 30 days, it's your responsibility to contact your insurance to expedite payment. **If your insurance does not pay, you are responsible for your payment.**

*There will be a $30.00 fee charge for all returned checks.

*If for some reason your account incurred an unpaid balance older than 30 days, it may be subject to collection placement and fees.

*I authorize this office to release necessary dental information about any dependants or myself to my insurance carrier.

FIXED OR REMOVABLE PROSTHETICS, such as dentures, crowns, or bridges, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made. We accept insurance payment for the covered portion; however, you must pay your portion at the time services are rendered.

Prosthetics must be seated in a timely manner to insure your comfort and proper fit. If you failed to have a prosthetic permanently seated within **60 days** from the date of the impression, or a second impression must be made, you will be charged a **$50.00 fee**. There will be no reimbursement on fixed or removable prosthetics.

All x-rays taken are part of our permanent records. There is a $25.00 duplication charge for any x-rays.

Thank you for choosing Park Dental Clinic and associates as your dental providers. We appreciate your trust and the opportunity to serve you.

_____ _____

Patient (Guardian) signature **Date**

Authorization for use or disclosure of patient photographic and/or video images

Name: _____ DOB:_____

Acknowledgement

- I authorize Park Dental Clinic and its employees to take photographs and/or videos to be used as a record of my care and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines)
- I also authorize Park Dental Clinic and its employees to take photographs and/or vides that may be used for marketing purposes (social media and/or advertising) by the practice. If this is the case, I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.
- I do not expect compensation, financial or otherwise, for the sue of these vides and/or photographs
- I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice vis registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed
- I understand that if the photographs and/or videos are used in any publication, as a part of a demonstration, on social media and/or advertising, my name (**first name only**) or other identifying information could be used unless stated differently below

Please initial one

_____ I do not mind if a first name and/or photos of face, jaws, mouth and teeth are used in any of the above stated situations

_____ I only agree to have teeth shown without any identifying features

_____ I do not wish to have a first name/face shown or released

_____ I do not wish to have the images used at all

_____ _____

Patient (Guardian) signature **Date**