Watauga Family Dentistry

WELCOME TO OUR PRACTICE

PATIENT INFORMATION: (Please Print) **TODAY'S DATE:_____**

Name First: _____Middle Initial: ____Last Name: _____Preferred Name:_____
Gender: M____F____ **Circle appropriate**: Minor Single Married Divorced Widowed Legally separated
Birth date: _____Social Security #:_____-_____-_____E-mail Address: _____
Home phone#:_____Office phone #:_____ Cell phone#:_____
Address: _____City:_____ ____State: _____Zip:_____
Emergency Contact: _____ Emergency phone #:_____
Your Employer: _____
Name of previous dentist. _____Phone #_____

Who may we thank for referring you? _____
Or, did you find us yourself? INTERNET TV NEWSPAPER YELLOW PAGES CLOSE TO HOME/WORK

RESPONSIBLE PARTY: (Please complete, if you are a minor or party is different than patient listed above)

Name of Person Responsible for this account: _____
Relationship to Patient_____ Is this person currently a patient in our office? YES / NO
Address: _____ City: _____ State: _____ Zip: _____
Birth date: _____ Social Security #: _____-_____-_____ Driver's License #: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Employer _____Occupation: _____

DENTAL INSURANCE INFORMATION: (Please provide a copy of your Dental insurance card)

Name of Insured: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Insured's Birth date: _____/_____/_____ Social Security #: _____-_____-_____
Employer: _____ Insurance Company: _____
Subscriber/Member ID#_____ Group/Plan # _____
Insurance Company Address: _____ City: _____ State: _____ Zip: _____
Have you used any of your insurance benefits this year? YES / NO If yes how much? _____

I certify that the above information is to the best of my knowledge accurate.

X_____ _____
PATIENT /RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT**

PATIENT MEDICAL HISTORY: (PLEASE CIRCLE ALL RESPONSES THAT APPLY)

Patient Name: _____ Date of Birth: _____

Your General Health: Excellent Good Fair Poor

Name of Physician: _____ Office Phone #: _____

Are you taking any medications, vitamins or herbal substances now? YES / NO If yes, why?_____

Name of Medications and dosage (prescription and non prescription): _____

_____

For women only: Are you pregnant? YES / NO Are you nursing? YES / NO

Are you taking birth control pills? YES / NO

NOTICE: Antibiotics may interfere with birth control pills rendering them ineffective.

Are you allergic to any medications? YES / NO If yes, please list: _____

Any other allergies: _____ Any unusual reactions to local anesthetics? YES / NO

Do you have any adverse reactions to Ibuprofen or Tylenol? YES / NO

Have you ever taken any prescription medicine for osteoporosis such as Boniva, Fosamax or Actonel? YES / NO

Have you ever been treated for any of the following? Circle ALL that apply:

Asthma	**Dry mouth/eyes**	**High Blood Pressure**	**Radiation Treatment**	**Ulcers**
Blood Disorders	**Epilepsy**	**Hip/Knee/Joint Replacement**	**Rheumatic Fever**	
Cancer	**Gerd**	**HIV Positive/AIDS**	**Sinus Problems**	
Chemical Dependency	**Heart Disease**	**Low Blood Pressure**	**STD'S**	
Chemotherapy	**Heart Murmur**	**Mitral Valve Prolapse**	**Stroke**	
Cholesterol	**Heart Valve Replacement**	**Prolonged Bleeding**	**Thyroid**	
Diabetes	**Hepatitis A B or C**	**Psychiatric Care**	**Tuberculosis/Lung Disease**	

Any other conditions or diseases? YES / NO If yes to any above, please explain: _____

Do you Smoke? YES / No Cigars? YES / NO Use smokeless tobacco? YES / NO

Approximate Date of your last dental visit?_____ Have you had difficulties with past dental treatment? YES / NO

Would you change anything about the appearance of your teeth? YES / NO If yes, what?_____

What is your Chief Dental Complaint? _____

Are you interested in Nitrous Oxide (Laughing Gas) for an additional charge? YES / NO

MEDICAL RELEASE: I authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. This Release will remain in effect until revoked by me **in writing**. A photocopy of this Release is to be considered as valid as the original. I certify that I have read and understand the above information and that to the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

CONSENT TO TREATMENT: I hereby authorize Watauga Family Dentistry and/or staff to do a thorough examination, take X-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I agree to allow the use of my photos/x-rays for the purposes of education and training. I have disclosed my health history information, including allergies, reactions to medicine, all drugs that I am currently taking, diseases, past procedures, pregnancy and drug use. I understand that withholding this information may affect the outcome of the procedure(s) and course(s) of treatment. I authorize Watauga Family Dentistry and /or any other qualified assistants of this practice to release information necessary to other physicians, specialists or dental providers as needed for my care. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment. I have read and understand the above and give my consent for treatment.

X_____ _____ _____

PATIENT, PARENT OR LEGAL GUARDIAN RELATIONSHIP TO PATIENT DATE

Watauga Family Dentistry

FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception medical and dental benefit policies their employers, or they individually have purchased, will pay for ALL their treatment. This is not the case. As a patient in this office, you will receive treatment specific to the problems noted during your initial examination. Your doctor will carefully review his findings with you and explain to you the treatment options available to you. In return, your financial responsibility for this treatment will be to the doctor's office. We will be glad to file your insurance claim for you to assist you in obtaining reimbursement for part of these benefits from your third party benefits payer. Often these third party payers, upon the patient's request, will send benefit reimbursement directly to the doctor's office. Please understand your benefits contract will always have an "allowable benefit" payment for each procedure provided. This "allowable" is determined by the limitations of the contract that your employer or the individual has purchased from the company and does not always equal the doctor's submitted fees. The third party payer will pay a percentage of the "allowable" with a co-payment portion assigned to the patient. Please understand third party payment is no longer termed "insurance" as it does not guarantee payment even though you may feel you have the coverage.

1. **I agree that I am responsible for ALL charges for dental services and materials regardless of what my dental insurance plan pays. I understand that full payment is expected at the time of service unless prior arrangements have been made.**
2. **In the event that benefits are assigned to the doctor, I authorize payment of the dental benefits to WATAUGA FAMILY DENTISTRY.**
3. **To the extent permitted under applicable law, I authorize release of any information relating to the proposed treatment or services rendered to my insurance company.**

Collection of Past Due Account Policy:

If payment is not received by the due date printed on the statement, then your account is considered "past due". If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency for collection, the account holder will be responsible for an additional 18% fee to cover a portion of the cost that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Refund Policy:

A patient may discontinue treatment and ask for a refund from Watauga Family Dentistry at any time. Watauga Family Dentistry will refund any amount paid for treatment that the patient has not received. Refunds will be mailed or transmitted within fifteen (15) business days after Watauga Family Dentistry receives your request. Refunds will be made in the same manner as the original payment with the exception of cash payments. Cash payments will be refunded by check.

I HAVE READ THE ABOVE FINANCIAL RESPONSIBILITY STATEMENT. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO WATAUGA FAMILY DENTISTRY FOR ALL CARE AND SERVICES PROVIDED TO ME.

_____ Date:_____

Patient Signature or Legal Guardian Signature

PLEASE RETAIN THIS AS YOUR COPY

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 protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on September 25, 2014, 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 provide the new Notice at our practice location, and we will distribute it 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. For example, we may disclose 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 provide to you. For example, we may send claims to your dental or medical health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example: 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 the following purposes, 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 You or Your Personal Representative: 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 personal representative 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 and disclose your 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 you 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use and disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use and disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or another crime; to report disease, injury and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

Watauga Family Dentistry

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, letters and email correspondence).

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. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $10.00 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. In most cases, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: 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 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 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 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.

Contact Office: Office Manager

Address: 5710 Watauga Rd. Ste B, Watauga, TX 76148

Telephone: 817-281-2061

Fax: 817-281-2064

HIPAA ACKOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices is posted in our lobby or we are happy to provide you a copy.
****You May Refuse to Sign this Acknowledgement****

I, _____, have reviewed a copy of this office's Notice of Privacy Practices, which is also posted in the practice lobby.

_____ Date:_____

Patient Signature or Legal Guardian Signature

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH AND FINANCIAL INFORMATION

I hereby give permission to WATAUGA FAMILY DENTISTRY to disclose and discuss any information related to my financial or medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s)

Name	Relationship
Name	Relationship

____I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition.

I wish to be contacted in the following manner:
Preferred contact number (please circle preference) **Home Cell Work**
Preferred written communication (please circle preference) **Home Work/Office Fax E-mail**

- **Phone number _____**
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- **Address _____**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand the requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient or Legal Representative Date

FOR OFFICE USE ONLY

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Private Practices, but acknowledgement could not be obtained because:
_____ Individual refused to sign _____Communications barriers prohibited obtaining the acknowledgement _____ An emergency situation prevented us from obtaining acknowledgment _____Other (Please Specify)_____
Patient Name:_____
_____

Watauga Family Dentistry

Appointment Policy

Everyone here at Watauga Family Dentistry is happy to help you with your dental needs. That includes being able to provide you an appointment when needed. Patients failing to attend scheduled appointments otherwise, known as a "NO SHOW", hinder our ability to assist you in your time of dental need. It also hinders our ability to provide the reserved time with any other dental needs that our other patients may have. In an effort to combat this issue, please read the following policy:

Your account will be charged a $25.00 "NO SHOW" fee per hour of appt:

- If your reserved appointment is missed without providing a **24 hour** notice. (Please note if your treatment requires an appointment lasting 2 hours or longer we require a 48 hour notice.)
- If you reschedule more than twice in a calendar year without proper notice listed above, you may be dismissed from the practice if you repeatedly "NO SHOW" for scheduled appointments without providing sufficient notice.
- We do need you to CONFIRM any appointment. If an appointment is not confirmed, it may be cancelled to allow another patient to take your place.

We appreciate your cooperation as we are here to provide our patients with quality care.

This is our office policy. By not signing, policy is still in effect and charge is still accessed.

I have read and understand the above Appointment Policy.

_____ _____

Signature of Patient or Legal Representative **Date**