Austin Dental Center, PC

2304 Hancock Dr #1 Austin, TX 78756

Date: _____

I, _____, give Austin Dental Center and its representatives
Patient Name

permission to discuss my personal health information with the following person (s):

_____

_____

_____ _____
Patient Signature Date

Time 7:06 AM | AUSTIN DENTAL CENTER, P.C | Date 8/18/2015

Eaglesoft Medical History (UPDATED)

Patient Name: | Birth Date: | Date Created:

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? If so, phone number?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Have you ever had joint replacement surgery?	○ Yes ○ No	If yes
Have you ever had a heart valve replacement?	○ Yes ○ No	
Have you ever had a heart problem or stent, or a pacemaker/implantable defibrillator in the last 6	○ Yes ○ No	
Do you use tobacco or any controlled substance? If yes, Type and Frequency?	○ Yes ○ No	If yes
Do you have dental anxiety?	○ Yes ○ No	
Do you need to be premedicated?	○ Yes ○ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Codeine	☐ Acrylic	☐ Metal
☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics	☐ Fluoride
☐ Erythromycin	☐ Tetracycline	☐ Penicillin	☐ Ibuprofen

Other? ☐ If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Current Medications:

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:

X Date:_____

Austin Dental Center, P.C.
Financial Options & Your Insurance Plan

The staff at Austin Dental Center, P.C. is proud to deliver the finest and most comprehensive health care available today! In addition, we are also dedicated to making top quality care as cost effective as possible.

Financial Options

Austin Dental Center, P.C. requests payment or assignment of payment at the time of service. We accept cash, check, American Express, MasterCard, VISA, Discover, Care Credit, and assignment of insurance benefits. In some circumstances we do offer extended financial options, BUT these arrangements must be made PRIOR to treatment.

Do you accept my insurance? How much will they pay?

The staff at Austin Dental Center is pleased that you have insurance benefits to help with the cost of your dental care and would like to help you obtain the maximum use of these benefits. Please read the information on our insurance claims process so that we can work together to ensure this benefit.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to go into a contractual agreement). This means that we work with literally thousands of companies. Although we can look at companies' past payment history, their policies do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know from your insurance company your insurance benefit for specific treatment, we will be happy to file a "pre-treatment authorization" with them prior to treatment. This does delay treatment and is still not always guaranteed by the insurance company.

I thought I paid my portion but I got a bill, why?

We base the patient portion of your bill on our most current data but there are many factors that can affect this estimate. Insurance companies have hundreds of plans and coverage varies from group to group, even within the same company. Therefore we can ask for general coverage information but they cannot relay to us every particular clause of your policy. Also, there may be a deductible (individual or family) or you may have received treatment in another office prior or in addition to Austin Dental Center which will not be calculated into our database. Sometimes you may need to see a specialist for care; this also uses your annual benefits. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they may only notify you.

Insurance did not pay, now what?

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Austin Dental Center reserves the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Austin Dental Center, P.C.

_____ _____

Signature Date

Appointment and Cancellation Policies:

Dental health is not a one-time affair. A plan of preventive dentistry along with a mutual understanding of joint responsibility for your dental health is the most important service we have to offer you. To remain an active patient in this office you will be included in our Preventive Dental Care Program and be expected to have a regular periodic examination and professional hygiene visit at lease twice a year. Sometimes health (dental and otherwise) necessitate more than two visits per year, in these cases, a maintenance schedule will be reviewed with you.

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give our office advanced notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. This best serves the needs of ALL patients.

Bearing these special needs in mind, the office requires a minimum of two (2) business days notice if an appointment must be cancelled **(3 business days in advance for appointments exceeding 2 hours). Our office hours are 7:00 AM to 5:00 PM, Monday through Thursday**. If less than 2 business days notice has been given to cancel an appointment or the patient does not show up for their scheduled appointment, we reserve the right to charge any patient a broken/cancelled appointment fee of $50 for a hygiene appointment and $75.00 for an appointment with Dr Glennon. Please note that this fee is not covered by dental insurance, payment is the patient's responsibility and must be paid before additional treatment is scheduled or performed.

I have read, understand, and accept the terms of the above outlined policies for appointment commitments at Austin Dental Center, P.C.

Signature _____Date _____

Austin Dental Center, P.C.

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 **April 2003**, 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.

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.

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.

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 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, email, postcards, or letters).

Additional 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 for treatment, payment, and healthcare operations described in this Notice.**

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may **not** disclose your health information to a family member, friend or other person unless you agree that we may do so.

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

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 $5.00 for each page, $30.00 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 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 Person: **Ariel Merriman**

Telephone: **512.454.0414** Fax: **512.454.0426**

E-mail: **ariel@smileaustin.com**

Address: **2304 Hancock Drive Ste. 1 Austin, TX 78756**

AUSTIN DENTAL CENTER, P.C

2304 Hancock Dr Ste 1 Austin TX 78756 www.smileaustin.com PH: 512-454-0414

Welcome to our Office!

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information *(confidential)*

Name: _____ Birthdate: _____ Marital Status:_____

Social Security #:_____ Home#:_____ Cell #:_____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Email: _____
Driver's License #:_____

When confirming appointments how do you prefer to be contacted? □ Phone □ Email □ Text Message

Patient or Parent's Employer: _____ Work Phone #: _____

Spouse or Parent's Name: _____

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

Person to contact in Case of Emergency: _____ Phone #: _____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient: _____

Contact #: _____ Birthdate: _____ SSN#: _____

Is this person currently a patient in our office? □ Yes □ No

Insurance Information

Name of Insured: _____ Relationship to Patient: _____ SSN#: _____

Birthdate: _____ Name of Employer: _____ Work#: _____

Insurance Company: _____ Insurance Phone#: _____

Policy/Member ID#: _____ Group #: _____

Today' Date: _____

Austin Dental Center, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

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 only***.

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 accompanies this Consent. 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 by contacting:

Contact Person: **Ariel Merriman**

Telephone: **512.454.0414** Fax: **512.454.0426**

E-mail: **ariel@smileaustin.com**

Address: **2304 Hancock Drive Ste. 1 Austin, TX 78756**

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 Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on 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.

SIGNATURE

I have received and read a copy of this office's Notice of Privacy Practices. I have had full opportunity to consider the contents of your Notice of Privacy Practices and this Consent for Use and Disclosure of Health Information. 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 healthcare operations only**.

Signature: _____ **Date:** _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.