Primary Dental Clinic

Date_____

First Name _____ Last Name_____

Address _____

City _____ State_____ Zip Code_____

Home Phone _____ **Cell Phone #**_____

Work Phone _____ Employer_____

Male____ Female____ Married/Single____ Social Security No._____

Date of Birth _____ Age____ Drivers' License No._____

HOW DID YOU HEAR ABOUT US? _____

Spouse or Parent's Name_____

Spouse or Parent's Work Phone_____

Spouse or Parent's Employer _____

Person & Phone # to contact in Emergency _____

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DENTAL INSURANCE INFORMATION

Name of Insurance Company_____

Employee's Name _____ Soc. Sec. #_____

Employer's Name _____ Date of Birth:_____

Employer's Address _____

Date Employed _____ Group Number_____

Ins. Co. Phone No. _____ Effective Date of Coverage_____

DO YOU HAVE TWO DENTAL INSURANCES?_____

Name of 2nd Insurance Company? _____

Employee's Name _____ Soc. Sec. #_____

Employer's Name_____

Employer's Address _____

Date Employed _____ Group Number_____

Ins. Co. Phone No. _____ Effective Date of Coverage_____

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient In the hospital during the past two years? YES NO
3. Have you been under the care of a medical doctor during the past two years? YES NO
   MEDICAL DOCTOR'S NAME _____
   ADDRESS _____
   PHONE NUMBER_____
4. Have you taken any medication or drug during the past two years? YES NO
5. Please list any medication, drugs or pills you are presently taking:
   _____

6. Have you ever had an allergic reaction to any drug medicine? YES NO
7. Please list any and all medicines you are allergic to:
   _____
   _____
8. Have you ever had an allergic reaction to any dental anesthetics? YES NO
9. Please list any dental anesthetics you may be allergic to:
   _____

10. Please circle any of the following health problems you have had:

Heart Problems	Sickle Cell Disease	Drug Addiction
Lung Problems	Heart Murmur	Tuberculosis
High Blood Pressure	Mitral Valve Prolapse	Cancer or Tumor
Rheumatic Fever	Artificial Heart Valve	Emphysema
Diabetes	Epilepsy or Seizures	Venereal Disease
Bleeding Tendencies	Heart Pacemaker	Blood Transfusion
Hepatitis	H. I. V. Positive	Bruise Easily
A. I. D. S.	Artificial Joints (knee, hip, etc.)	Stroke
Glaucoma	Cold Sores/Fever Blisters	Pain in Jaw Joint
Chemotherapy	Radiation Therapy	Cosmetic Surgery
Thyroid Problems	Fainting or Dizzy Spells	

11. PLEASE LIST ANY PROBLEMS, DISEASE, OR CONDITION YOU MAY HAVE THAT IS NOT LISTED:

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12. Women Patients: Are you pregnant? ---------- If so what month?_____
    Are you nursing? ---------- Are you taking birth control pills?_____

CONSENT:

I have answered the medical questions truthfully and to the best of my knowledge. I understand the information is needed to provide me with dental care in a safe and efficient manner. I authorize the Doctor to take any necessary x-rays, photographs, study models or other diagnostic aids which may be necessary for the Doctor to make a thorough diagnosis of my dental needs. I authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be needed. I understand that the use of anesthetic agents embodies a certain risk. I also understand the responsibility for payment for dental services is mine, due and payable at the time the services is rendered unless other financial arrangements have been made. I further understand that a 1 ½% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

PATIENT SIGNATURE: ---------- Date:_____

PRIMARY DENTAL CLINIC

[Name of Practice]

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. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this **Notice** and to maintain the privacy of your health information. We must also abide by the terms of this **Notice** while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

How We May Use and Disclosure Your Protected Health Information

You will be asked to sign an **Acknowledgement Of Receipt Of Notice Of Privacy Practices** when we give you our **Notice of Privacy Practices**. Once you have received our **Notice**, we will use your protected health information for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information to contact you to remind you of your appointment. We may send you information about treatment alternatives or products and services that may be of interest to you. We may also use your name to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information.

Your Written Authorization Is Required For Other Uses Of Your Protected Health Information

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our practice has already released your health information as provided for in your authorization.

How We Will Use Your Health Information With Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object (such as in an emergency) to the use or disclosure to the protected health information, then we may use professional judgement and common practice to determine whether the disclosure is in your best interest. In this case, only the protected health information that is needed to provide your health care will be disclosed.

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgement and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescription or other similar forms of health information.

Other Disclosures That May Be Made Without Your Consent

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

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement Of Receipt Of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose your health information using our professional judgement, disclosing only health information that is necessary to provide your health care.

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 and safety of others.

Military Personnel and National Security: We may disclose the health information of Armed Forces personnel when requested by command military authorities. 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, the protected health information of inmates under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

You Have The Following Rights

Inspect and copy your protected health information. 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 practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending us a letter using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Request a restriction of your protected health information. 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.

Request 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 payments will be handled under the alternative means or location you request.

Request an amendment to your health information. You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

Receive an accounting of disclosures we have made of your health information. You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee.

Make a complaint about our privacy practices. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint or change the way we treat you.

To obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: **04/01/03**

Privacy Officer: **Carol Diaz** Telephone: **432-570-7080**

Address: **4519 N. Garfield #16A, Midland, TX 79705**

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, _____ have received a copy of
(Name of Patient)

_____Primary Dental Clinic_____ Notice of Privacy Practices
(Name of Practice)

_____
(Signature of Patient)

Staff will fill out if patient's signature is not obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

___ Patient refused to sign.

___ Emergency situation kept us from obtaining patient's signature.

___ Language barriers kept us from obtaining the patient's signature.

___ Other _____

PRIMARY DENTAL CLINIC

4519 North Garfield, Suite 16 • Midland, Texas 79705 • (915) 570-708

DISCLAIMER:

INSURANCE COVERAGE IS ESTIMATED - YOUR ACTUAL INDEMNITY MAY BE LESS. YOU THE PATIENT, ARE RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY YOUR INSURANCE CARRIER. YEAR-TO DATE USED BENEFITS AND REMAINING DEDUCTIBLE AMOUNTS ARE NOT AFFECTED UNTIL THE PROCEDURE IS COMPLETED AND THEREFORE ARE NOT USED IN THIS DETERMINATION OF BENEFITS.

PATIENT SIGNATURE _____ DATE _____