Welcome To Our Office

Date _____
Patient Name _____ Birth Date_____
Address _____ City _____ Zip Code _____
Home Phone_____ Cell Phone _____ Soc Sec # _____
Email Address _____

EMPLOYMENT INFORMATION

Name of Employer _____ Phone # _____

DENTAL INSURANCE INFORMATION

Name of Ins. Co._____ Insured's Employer_____
Name of Insured (if different from patient) _____ Insured's Date of Birth _____
Insured's Soc Sec # _____ Insured's Relationship to Patient _____
Group #/ Group Name _____ Insured Retired? From What Company _____

SPOUSE,PARENT OR RESPONSIBLE PARTY

Name _____Relationship to Patient _____
Address _____City/Zip Code _____
Employer _____ Phone # _____

DENTAL HISTORY

Do you see a dentist regularly? YES NO If yes, name of dentist _____ How Long? ____

DENTAL CONDITION (CIRCLE YES OR NO)

HAVE YOU EVER:

Been told you have gum trouble?..... ...Yes No
Have you had trench mouth?..... Yes No
Been treated for periodontal Disease?... Yes No
Had orthodontic treatment?.....Yes No

DO YOU EVER:

Do you clench your teeth?.....Yes No
Do you have swollen gums? .....Yes No
Do you have bleeding gums?.... Yes No
Do you have tooth sensitivity?...Yes No

Are you unhappy with the appearance of your teeth or smile?.....Yes No
Would you be disturbed if you lost your teeth?..... Yes No

FOR WOMEN ONLY

Are you pregnant?.....Yes No If yes, what month ____ Are you nursing?..... Yes No
Are you taking birth control pills?.....Yes No Have you been through menopause?.....Yes No
Are you taking hormonal supplements?.....Yes No

MEDICAL CONDITION (CIRCLE YES OR NO)

DO YOU HAVE OR HAVE YOU EVER HAD:

Heart failure .....Yes No
Heart Disease..... Yes No
Heart Attack..... Yes No
Congenital Heart Defect....Yes No
Congenital Heart Disease .Yes No
Stroke.....Yes No
Arthritis.....Yes No
Rheumatism.....Yes No

Heart Murmur..... Yes No
High Blood Pressure..... Yes No
Low Blood Pressure .....Yes No
Heart Pacemaker .....Yes No
Rheumatic Fever .....Yes No
Blood Thinners .....Yes No
AIDS.....Yes No
HIV Positive.....Yes No

Arteriosclerosis .....Yes No
Mitral Valve Prolapse.....Yes No
Artificial Heart Valve.....Yes No
Heart Surgery.....Yes No
Rheumatic Heart Disease..... Yes No
Angina Pectoris.....Yes No
Blood Transfusions.....Yes No
Hemophilia.....Yes No

Pain in Jaw (TMJ)..... Yes No
Ever Taken Cortisone.....Yes No
Artificial Joint..... Yes No
Kidney Disease.....Yes No
Liver Disease.....Yes No
Yellow Jaundice.....Yes No
Thyroid Disease.....Yes No
Diabetes.....Yes No
Ulcers.....Yes No
Hiatal Hernia.....Yes No
Cancer.....Yes No
Radiation Therapy.....Yes No
Sinus Trouble.....Yes No
Cataracts.....Yes No
Cosmetic Surgery.....Yes No
Height:_____

Frequent Headaches..... Yes No
Cold Sores/Fever Blisters.Yes No
Do You Smoke.....Yes No
History of Smoking..... Yes No
Drink Alcohol..... Yes No
Phen-Fen Diet Medication.Yes No
Emphysema.....Yes No
Chronic Cough..... Yes No
Tuberculosis.....Yes No
Asthma.....Yes No
Hay Fever.....Yes No
Allergies or Hives.....Yes No
Hepatitis A (infectious).....Yes No
Hepatitis B (serum).....Yes No
Hepatitis C.....Yes No
Weight: _____

Blood Disorder Anemia.....Yes No
Sickle Cell Disease.....Yes No
Bruise Easily.....Yes No
Drug Addiction.....Yes No
Epilepsy or Seizures.....Yes No
Ever Fainted.....Yes No
Dizzy Spells.....Yes No
Nervousness.....Yes No
Psychiatric Treatment.....Yes No
Osteopenia/Osteoporosis.....Yes No
Biophosphonates Meds.....Yes No
Chemotherapy.....Yes No
Glaucoma.....Yes No
History of Surgery.....Yes No
_____
_____
_____

HAVE YOU OR DO YOU:

Been under the care of a physician in the last year.....YesNo Reason:_____
Had a major illness.....YesNo Reason:_____
Take aspirin daily.....YesNo Reason:_____
Had abnormal bleeding tendencies ("Free bleeder", Hemophilia or prolonged bleeding after extraction)..... Yes NO

PLEASE LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING

Name_____ Reason_____ Dosage _____
Name_____ Reason_____ Dosage _____
Name_____ Reason_____ Dosage _____
Name_____ Reason_____ Dosage _____
Name_____ Reason_____ Dosage _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO MEDICATIONS..... Yes No
If yes, name of medication(s)_____
_____

PHARMACY YOU USE _____ **PHONE NUMBER** _____
NAME OF PHYSICIAN _____ **PHONE NUMBER** _____

CONSENT

The undersigned hereby authorizes the doctor or staff to take radiographs (x-rays), study models, photographs, or any diagnostic aids deemed appropriate to make a thorough diagnosis. All responsibility of payment for Dental Services provided in this office for myself or my dependent is totally mine, due and payable at the time of services unless a previous financial arrangement has been made.

I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner. I will inform the doctor of any changes in my medical history and any changes in my medications.

Patients Signature_____ Date _____
(Guardian if patient is a minor)
Dentist Signature _____ Date _____

Acknowledgement of Privacy Policy

Implant and Periodontal Dentistry
412 River Road, Suite 101-Boerne, TX 78006
717 Barnett- Kerrville, TX 78028

You May Refuse to Sign this Acknowledgement

I have received a copy of the Notice of Privacy Practices for Implant and Periodontal Dentistry.

Today's Date _____

Print Your Name _____

Your Signature _____

Please list anyone we may share your information with:

_____

Name Relationship Phone Number Your Signature

_____

Name Relationship Phone Number Your Signature

Please list an emergency contact:

_____

Name Relationship Phone Number Your Signature

I authorize the use of Text Messaging..... YES NO _____
(Data Rates May Apply) Your Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An Emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

IMPLANT AND PERIODONTAL DENTISTRY

Cancellation/ No Show Policy
For Doctor Appointments and Surgery

Cancellation/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call to cancel your appointment; you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty-Five Dollar ($25) fee.**

Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and doctors on scheduled time.
If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Cancellation/No Show Policy for Surgeries

Due to the large block of time needed for your surgery, last minute cancellations can cause problems and added expenses to our office.
If surgery is not cancelled at least 24 hours in advance you wll be charged a Twenty-Five Dollar ($25) fee.

Account Balances

We will require that patients who are self pay to pay their account balance to zero prior to receiving further services by our practice. Patients who have questions about their bill or would like to discuss a payment plan option may call and ask to speak with an office representative with whom they can review their account and concerns. Patients with a balance over One Hundred Dollars ($100) must make payment arrangements prior to future appointments being scheduled.

_____ _____

Print Name Signature Patient/Guardian

_____

Date

Tony Dacy DDS,MS Mitchell Ponsford DMD, MS Glenn Mattlage DDS,MS

412 River Rd-Suite 101 Boerne, TX 78006 717 Barnett Kerrville, TX 78028

Implant and Periodontal Dentistry

412 River Road, Suite 101 – Boerne, Texas 78006

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 the 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 October 2006 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 anytime, 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.

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 the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes.

TREATMENT: We use and disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental 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.

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 your personal representative, but only if you agree we may do so.

PERSONS INVOLVED IN CARE: We may use and 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, 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 absence or incapacity or in 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 and 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 report abuse, neglect or domestic violence; 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.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 an 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 or letters).

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 that 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. You may also request 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 $2.00 for each page, $50.00 per hour for staff time to copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge you 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 six (6) years, from the current date your are requesting. 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 healthcare operations (as defined by HIPAA) if the protected health information pertains solely to a healthcare item or service for which we have been paid out of pocket in full.

ALTERNATIVE COMMUNICATIONS: You have the right to request that we communicate with you about your health information for alternative means or at alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation of 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: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our web site or by electronic mail (e-mail).

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 an alternative location, 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 Humana 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 Officer:	Office Manager		
Telephone:	830-816-5102	Fax:	830-331-9535
E-mail:	info@ipdentistry.com		
Address:	412 River Road, Suite 101	Boerne, Texas 78006	