

Welcome To Our Office

Date _____

Patient Name _____ DOB _____

Address _____ City _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Email Address: _____

EMPLOYMENT INFORMATION

Name of Employer _____ Phone Number _____

DENTAL INSURANCE INFORMATION

Name of Ins. Co. _____ Insured's Employer _____

Name of Insured (if different from patient) _____ Insured's DOB _____

Insured's SSN _____ Insured's Relationship to Patient _____

Group Name/Group # _____ Insured Retired? From What Company _____

EMERGENCY CONTACT OR RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____ City/Zip Code _____

Employer _____ Phone Number _____

DENTAL HISTORY

Do you see a dentist regularly?.....Yes No If yes, name of Dentist _____

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

Are you unhappy with the appearance of your teeth or smile?...Yes No

Would you be disturbed if you lost your teeth? 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

FOR WOMEN ONLY:

Are you pregnant? Yes No Are you taking birth control pills?..... Yes No

If yes, what month? _____ Are you taking hormonal supplements?..... Yes No

Are you nursing?..... Yes No Have you been through menopause?..... Yes No

MEDICAL CONDITON (CIRCLE YES OR NO)

DO YOU HAVE OR HAVE EVER HAD:

AIDS Yes No Arthritis Yes No Bisphosphonate Meds..... Yes No

Allergies or Hives Yes No Artificial Heart Valve Yes No Blood Disorder Anemia Yes No

Angina Pectoris Yes No Artificial Joint..... Yes No Blood Thinners..... Yes No

Bruise Easily Yes	No	Glaucoma Yes	No	Mitral Valve Prolapse..... Yes	No
Cancer..... Yes	No	HIV Positive..... Yes	No	Nervousness..... Yes	No
Cataracts..... Yes	No	Hay Fever..... Yes	No	Osteopenia/Osteoporosis . Yes	No
Chemotherapy..... Yes	No	Heart Attack..... Yes	No	Pain in Jaw (TMJ)..... Yes	No
Chronic Cough..... Yes	No	Heart Disease..... Yes	No	Phen-Fen Diet Medication Yes	No
Cold Sores/Fever Blisters . Yes	No	Heart Failure..... Yes	No	Psychiatric Treatment..... Yes	No
Congenital Heart Defect.... Yes	No	Heart Murmur..... Yes	No	Radiation Therapy..... Yes	No
Congenital Heart Disease . Yes	No	Heart Pacemaker..... Yes	No	Rheumatic Fever..... Yes	No
Cosmetic Surgery..... Yes	No	Heart Surgery..... Yes	No	Rheumatic Heart Disease . Yes	No
Diabetes..... Yes	No	Hemophilia..... Yes	No	Rheumatism..... Yes	No
Dizzy Spells..... Yes	No	Hepatitis A (Infectious)..... Yes	No	Sickle Cell Disease..... Yes	No
Do You Smoke..... Yes	No	Hepatitis B (Serum)..... Yes	No	Sinus Trouble..... Yes	No
Drink Alcohol..... Yes	No	Hepatitis C..... Yes	No	Stroke..... Yes	No
Drug Addiction..... Yes	No	Hiatal Hernia..... Yes	No	Thyroid Disease..... Yes	No
Emphysema..... Yes	No	High Blood Pressure..... Yes	No	Tuberculosis..... Yes	No
Epilepsy or Seizures..... Yes	No	History of Smoking..... Yes	No	Ulcers..... Yes	No
Ever Fainted..... Yes	No	Kidney Disease..... Yes	No	Yellow Jaundice..... Yes	No
Ever Taken Cortisone..... Yes	No	Liver Disease..... Yes	No	List of Surgeries: _____	
Frequent Headaches..... Yes	No	Low Blood Pressure..... Yes	No	_____	
Height: _____		Weight: _____		_____	

Been under the care of a physician in the last year? ...Yes No Reason _____
 Had a major illness? Yes No Reason _____
 Take aspirin daily? Yes No 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:** _____

DATE OF LAST PHYSICAL: _____

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 _____

**Cancellation and No Show Policy
for Doctor Appointments and Surgery**

1. Doctor Appointments:

We understand that there are times you may have to miss an appointment due to an emergency or unforeseen obligation. However, when you do not call to cancel your appointment, it prevents another patient from receiving much needed treatment. Conversely, the situation may arise where a patient fails to cancel which leaves us unable to schedule you an appointment due to seemingly "full" schedule. **Therefore, if you miss your appointment or your appointment is not cancelled 24 hours in advance, a \$25 fee will be assessed; this fee is not covered by your insurance.**

2. Surgeries:

Due to the large amount of time allotted for your surgery, last minute cancellations can cause issues and added expenses for the office. **Therefore, if your surgery is not cancelled at least 24 hours in advance, a \$25 fee will be assessed; this fee is not covered by your insurance.**

3. Scheduled Appointments:

We understand that delays can happen, however, we strive to keep patient appointments and our doctors on a timely schedule. **Therefore, your appointment will need to be rescheduled if you arrive 15 minutes passed your scheduled appointment time.**

Account Balance Policy

We require all patients to pay their account balance in full prior to receiving further services. Payment arrangements must be made for any account with a balance exceeding \$100 prior to scheduling future appointments. If you have questions about your account or would like to discuss payment plan options, please ask to speak with an office representative. They will be glad to review your account to address any questions or concerns.

I have read and acknowledge the above policies regarding appointments, surgeries, and account balances.

Signature Patient/Guardian

Print

Date

Acknowledgement of Privacy Policy

Implant and Periodontal Dentistry
412 River Road Boerne, TX 78006
717 Barnett Kerrville, TX 78028
707 S. Adams St. Fredericksburg, TX 78624

*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

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

Date: _____

Print Name: _____

Signature: _____

Please list anyone we may share your information with below:

Name	Relationship	Phone No.	Signature
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Name	Relationship	Phone No.	Signature
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I authorize the use of text message.....YES/NO _____
(Data Rates may apply) **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 one or more of the following:

- Individual refused to sign
- Communication barriers
- An emergency situation arose
- Other (please specify below)

Implant and Periodontal Dentistry

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 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. 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 you 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 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 Officer: Office Manager

Telephone: (830)896-6964 ; (830)816-5102 or (830)997-9505 Fax :(830)257-1206

E-mail: info@ipdentistry.com

Address: 717 Barnett Kerrville, Texas 78028 707 S. Adams St. Fredericksburg, Texas 78624
412 River Road Boerne, Texas 78006