Patient Information… Date:

❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name M.I. Last Name Preferred Name

Sex: ❑ Male ❑ Female Birth Date Age Soc. Sec. # Driver's Lic.#

E-mail

Street City State Zip

Home Phone # Cell Phone # Work Phone #

In case of emergency, please contact Phone # Relation

Who will be responsible for your account…

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other

Name Soc. Sec.# Birth Date Age Phone #

Street City State Zip

Employer Phone #

Spouse or other guarantor information (if different from above)…

Name Relation Soc. Sec.# Birth Date

Street City State Zip

Cell Phone # Employer Employer Phone #

Insurance Information…

Student:.....❑ Full Time ❑ Part Time ❑ Not.....School Name and Address

Marital Status:....❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated

Employed:.....❑ Full Time ❑ Part Time ❑ Retired ❑ Not.....

Ins. Co. Name Address Tel.( )

ID# Group # Group Name

Employer

Subscriber Soc. Sec. # Relation Sex: ❑ M ❑ F Birth Date

Street City State Zip Cell Phone #

How did you hear about us?

West Bluff Dental Care

Alexander Smith, D.M.D.

Name **Birth Date**

E-mail **Cell #**

Physician's Name **Physician's Phone #**

Date of your most recent visit to your physician **Reason**

How would you assess your general health? ❑**Good** ❑**Fair** ❑**Poor**

Office Use Only
Date:

Pre-medication ❑Yes ❑No

Comments:

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. All information will be considered confidential and for our records only.

	Yes	No
1. Are you seeing a physician at the present time for the treatment of a recent or ongoing condition? Date of last physical…	❑	❑
2. Have you been hospitalized, had a serious illness or operation within the last year? If yes, explain:	❑	❑
3. Have you ever had any serious medical trouble with any dental experience? If yes explain:	❑	❑
4. Have you ever been advised to take antibiotics (like penicillin, etc.) before a dental appointment? If yes, explain:	❑	❑

Do you now or have you had any of the following diseases or problems?

Cardiovascular Disease?	❑	❑
Are you short of breath after mild exercise?.....	❑	❑
Do your ankles swell?.....	❑	❑
Do you get short of breath when you lie down?...	❑	❑
Do you have chest pain upon exertion?.....	❑	❑
Abnormal bleeding or extended clotting time?.....	❑	❑
Frequent or unexpected nose bleeds?.....	❑	❑
Do you consider yourself currently under an abnormally high amount of stress?.....	❑	❑
Have you had any unexplained or unplanned weight loss recently?.....	❑	❑
Have you ever had an adverse reaction like nausea, dizziness, or feeling "spacey" with any drug or medication?.....	❑	❑

If yes check any that apply:

- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Angina
- ❑ Stroke
- ❑ Pacemaker
- ❑ Hardening of the arteries
- ❑ Congestive Heart Failure
- ❑ Mitral Valve Prolapse
- ❑ Coronary Bypass
- ❑ Artificial Heart Valve
- ❑ Congenital Heart Defects

CHECK ANY THAT APPLY:

- ❑ Allergies
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Angina
- ❑ Asthma
- ❑ Arthritis
- ❑ Artificial Joint
- ❑ Autoimmune Disease
- ❑ Blood Disorder
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chronic/Recurring Cough
- ❑ Cirrhosis
- ❑ Depression
- ❑ Diabetes
- ❑ Drug or Alcohol Treatment
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Fever Blisters
- ❑ Glaucoma
- ❑ Herpes
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Jaundice/Liver Disease
- ❑ Kidney Disease
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ Parkinson's Disease
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Serious/Freq. Headaches
- ❑ Sinus Problems
- ❑ Skin Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other

Please explain any checks from list.

Do you have any disease, condition or problem not listed that you feel we should know about?

	Yes	No
Do you now or have you ever smoked?	❑	❑
If you currently smoke, how much?		

❑ Cigarettes ❑ Pipe ❑ Cigar ❑ Other

If you have smoked in the past but no longer smoke, when did you quit?

Do you use any smokeless tobacco?	❑	❑
If yes, how often?		

WOMEN:

Are you currently pregnant?	❑	❑
If yes, expected delivery date		
Are you taking birth control pills?	❑	❑

Have you ever taken any <u>BISPHOSPHONATE</u> medication used for osteoporosis? ❑ ❑

Are you <u>ALLERGIC</u> to any of the following (do you get hives, a rash, have trouble breathing, etc.):

❑ Antibiotics (penicillin, tetracycline, etc.)
❑ Local Dental Anesthetics
❑ Sulfa Drugs
❑ Codeine (pain medications)
❑ Aspirin
❑ Barbiturates or Sedatives
❑ Tranquilizers
❑ Latex
❑ Others

	Yes	No
Is there anything you would like to change about your smile and discussed during your appointment?	❑	❑

If yes, check all that apply.

❑ **Whitening**
❑ **Straighter Teeth**
❑ **Veneers (laminates for teeth)**
❑ **Missing Tooth Options**
❑ **Other**

If you are <u>currently</u> taking these medications, check the box on the left. If you have taken any of these medications within the <u>past year</u>, but are not taking them currently, check the box on the right.

Now	Past Year	
❑	❑	Antibiotics
❑	❑	Antidepressants (Prozac, Zoloft, etc.)
❑	❑	Antihistamines
❑	❑	Aspirin
❑	❑	Bisphosphonates (Fosamax)
❑	❑	Blood Pressure Medication
❑	❑	Blood Thinners
❑	❑	Cortisone (Prednisone, etc.)
❑	❑	Cholesterol Medication
❑	❑	Decongestants
❑	❑	Diuretics (water pills)
❑	❑	Hormones (birth control pills, estrogen)
❑	❑	Inhalants
❑	❑	Insulin
❑	❑	Medicine Heart Problems
❑	❑	Muscle Relaxants
❑	❑	Nitroglycerine
❑	❑	Over-The-Counter Pain Medicine
❑	❑	Prescription Pain Medicine
❑	❑	Sleeping Pills
❑	❑	Thyroid Medicine
❑	❑	Tranquilizers
❑	❑	Vitamins
❑	❑	Others

Please list the medications you are currently taking.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X	**X**	**X**	**X**
Signature of Patient (Parent or Guardian if Minor)	**Date**	**Reviewed By**	**Date**

West Bluff Dental Care
Alexander D. Smith, D.M.D. PLLC
Office: 817-573-2652 Fax: 817-279-7116

Mission Statement

Our caring team is committed to providing our patients with a comfortable environment, exceptional dental care, answers to your dental questions, and a treatment plan that is customized for you.

Office Policies

- A broken or missed appointment is a loss to everyone and we have reserved this time especially for you. As a courtesy, please allow a 48-hour notice for any schedule changes. Please know that we reserve the right to assess a $50 fee for broken or missed appointments.

- As a courtesy we will accept and file your PPO insurance for you**, HOWEVER, WE ARE NOT A PARTICIPATING PROVIDER. THIS MEANS YOU ARE RESPONSIBLE FOR THE DIFFERENCE BETWEEN OUR FEE AND THE INSURANCE'S ALLOWABLE FEE.**

- If you have a secondary insurance, it does not mean that this combined insurance will cover our services at 100%. It is up to you, the insured, to know how the two dental plans will coordinate benefits. We will file your primary dental insurance for you as a courtesy. You will be responsible for filing any additional insurance.

- I am aware that some procedures are subject to a deductible. If the deductible has not been met then I will pay this at the time services are rendered.

- I hereby agree to assign all insurance payments to Alexander D. Smith DMD PLLC. I am aware that my insurance company may not cover all the professional fees. I hereby agree to pay, within 30 days, any outstanding balance following payment by my insurance company unless other financial arrangements have been made.

- I agree that if the insurance fails to pay Dr. Smith within 60 days of the rendered treatment all, fees are due and payable at that time.

- In the event the insurance company pays me, the patient instead of Dr. Smith, I agree to forward the payment to Dr. Smith.

- In the event a check is returned from a financial institution, I will be charged a returned check fee of $30.00.

- In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs as may be required to effect the collection of this note. This means that I may not be responsible for my total account balance, but also for an additional amount up to 50% of that amount which is the collection agency fee.

- I am aware that I am responsible for the account.

Signature_____ **Date**_____

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, _____, have received a copy of West Bluff Dental Care's Notice of Privacy Practices.
(Name of Patient)

_____ _____
Signature Date

Staff will fill out this section if patient's signature not obtained.
Our office made a good faith effort to obtain Acknowledgement of Receipt of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

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

_____ Other_____

In the event a family member or caregiver attends my office visit and is in the exam room at the time of any evaluation and/or treatment, I give West Bluff Dental Care my **permission to discuss freely my condition, treatment, diagnosis, or appointment time with that person.**

□ YES □ NO

I wish to be contacted in the following manner (check all that apply):
□ Home □ Cell Telephone Number
□ O.K. to leave a message with detailed information
□ Leave message with call back number only
□ Work Telephone Number
□ O.K. to leave a message with detailed information
□ Leave message with call back number only
□ E-mail
□ O.K. to mail to my e-mail address

May we call your name in our lobby? □ Yes □ No

With whom may we discuss or release information about your care, treatment or diagnosis?

_____ Relationship_____ Phone Number_____

_____ Relationship _____ Phone Number_____

With whom may we **NOT** discuss or release information about your care, treatment or diagnosis?

_____Relationship _____Phone Number_____

Signature: _____ (signature is valid one year from above date)

Printed Name_____

Legal Guardian/ Power Of Attorney: _____

Printed Name: _____

Notice of Privacy Practices

West Bluff Dental Care
Alexander D. Smith, D.M.D. PLLC

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 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 Disclose 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 make 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 (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 of the protected health information, then we may use professional judgment 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 judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.