NGFD NORTH GARLAND FAMILY DENTAL

# Patient Registration

First Name: _____ Last Name _____

Preferred Name:_____ Patient is: ____Policy Holder ___Responsible Party

--Responsible Party (if someone other than the patient)

| | | |
|---|---|---|
| First Name | | Last Name |
| Street Address | | City, State, Zip |
| Home Phone | Work Phone | Cell Phone |
| Date of Birth | Social Sec # | Drivers Lic # |

--Patient Information

| | | |
|---|---|---|
| First Name | | Last Name |
| Street Address | | City, State, Zip |
| Home Phone | Work Phone | Cell Phone |
| Date of Birth | Social Sec # | Drivers Lic # |
| Sex ☐ Male ☐ Female | Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed | |

E-mail Address:_____

As a patient at North Garland Family Dental, you will be seen by appointment for your dental care to minimize your waiting time in our reception area and to maximize efficiency of your dental care. We take your dental care very seriously, and will attempt to notify you of upcoming dental appointments with reminders and confirmations using text, E-mail and US Mail services. Opting out of these services limits our ability to communicate with you as your dental health provider. Providing your email address authorizes us to communicate with you via email. We are diligent with our efforts to minimize the volume of communications with you. Your information will never be shared with any unauthorized entity.

--Employment Status ☐ Full time ☐ Part-Time ☐ Retired Spouse: _____

| | | |
|---|---|---|
| Student Status ☐ Full Time ☐ Part-Time | | Spouse Work #: |
| Employer: | | Emergency Contact Person: |
| Employer ID: | Insurance Carrier ID: | Emergency Contact #: |
| Preferred Dentist: | Preferred Pharmacy: | Primary Care Physician & Phone # |

--Insurance Information

| | |
|---|---|
| Name of Insured: | Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other |
| Insured Social Sec #: | Insured Birth Date: |
| Employer: | Insurance Company |
| Address: | Address |
| City, State, Sip | City, State, Sip |

Whom may we thank for referring you? _____

## Dental Insurance Coverage

Kindly supply us with detailed insurance information. We will be happy to assist you with filing your insurance claim. Please note this is a courtesy we offer our patients, and we cannot be responsible for claims that are denied for any reason.

NGFD NORTH GARLAND FAMILY DENTAL

# Medical History

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medications 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? ___ *Yes* ___ *No* *N/A* _____

Have you ever been hospitalized or had a major surgery? ___*Yes* ___*No* *(Explain)* _____

Have you ever had a serious neck or head injury? ___*Yes* ___*No* *(Explain)* _____

Are you taking any medications, pills, or other drugs? ___*Yes* ___ *No* *(If Yes, Please list.)*

_____

Do you take, or have taken, Phen-Fen or Redux*?* ___ *Yes* ___*No* Are you on a special diet? ___*Yes* ___*No*

Do you use a controlled substance? ___*Yes* ___*No* Do you use tobacco? ___*Yes* ___*No*

Women: *Are you Pregnant/Trying to get pregnant?* ___*Yes* ___ *No* *Nursing?* ___ *Yes* ___ *No*

*Taking oral contraceptives?* ___*Yes* ___ *No*

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following? Check all that apply to your situation.

Blood Disorders:
__ Aids/HIV Positive
__ Anemia
__ Excessive Bleeding
__ Hemophilia
__ Leukemia
__ Sickle Cell Disease
__ Blood Transfusion
__ Bruise Easily

Heart Problems:
__ Angina
__ Chest Pains
__ Heart Attack/Failure
__ Artificial Heart Valve
__ Mitral Valve Prolapse
__ Irregular Heartbeat
__ Heart Pace Maker
__ Heart Murmur
__ Congenital Heart Disorder
__ Rheumatic Fever
__ Scarlet Fever

__ Stroke
__ Fainting Dizzy Spells
__ High Blood Pressure
__ Low Blood Pressure

Tumors/Growths:
__ Cancer
__ Chemotherapy
__ Radiation Treatments

Allergies/Breathing Problems:
__ Asthma
__ Emphysema
__ Frequent Cough
__ Hives/Rash
__ Hay Fever
__ Sinus Trouble
__ Lung Disease
__ Tuberculosis

Bones/Joints:
__ Artificial Joint
__ Arthritis/Gout
__ Rheumatism
__ Swelling of Limbs
__ Cortisone Medicine

Abdominal:
__ Ulcers
__ Kidney Problems
__ Renal Dialysis
__ Liver Disease
__ Hepatitis A B C
__ Yellow Jaundice
__ Hypoglycemia
__ Diabetes
__ Excessive Thirst
__ Frequent Diarrhea

Head/Neck Problems:
__ Thyroid Disease
__ Parathyroid Disease
__ Pain in Jaw Joint

__ Tonsillitis
__ Frequent Headaches
__ Cold Sores/Fever Blisters
__ Convulsions/Seizures
__ Anaphylaxis
__ Epilepsy
__ Glaucoma
__ Spina Bifida
__ Psychiatric Care
__ Alzheimer's Disease
__ Recent Weight Loss
__ Drug Addiction
__ Herpes/Genital Herpes
__ Shingles
__ Venereal Disease
Other:
_____
_____
_____
_____

NGFD NORTH GARLAND FAMILY DENTAL

# Dental History

Chief Oral Complaint/Problem _____

_____

Are you satisfied with the appearance of your teeth ___ Yes ___ No Explain _____

_____

Date of Last Dental Visit _____ What services were done at that time? _____

Previous Dentist Name _____City _____

Please check all that apply:

| | | |
|---|---|---|
| ___Teeth Sensitive to cold/hot/sweets/pressure | ___ Food Impaction between teeth | ___ Burning of Tongue |
| ___ Swelling or lumps in mouth | ___ Clenching or grinding of teeth | ___ Bleeding gums |
| ___ Frequent blisters on lips or mouth | ___ Unfavorable dental experience | ___ Bad Breath |
| ___ Pain around ear/TMJ Disorder | ___ Complications from Extractions | ___ Mouth Breathing |
| ___ TMJ Clicking or popping | ___Do you gag easily | ___ Unpleasant taste |
| ___ Periodontal treatment (Gums) | ___ Oral habits (fingernail biting, etc.) | ___ Orthodontics (braces) |

Have you ever used Nitrous oxide (laughing gas) for dental treatment? ___ Yes ___ No
Were there complications?

Texture of your toothbrush ___Soft ___Hard Frequency of brushing _____/Day

As part of your oral hygiene regimen, do you use

___Dental Floss? Frequency _____

___ Interdental Stimulators

___Water Jet Device

___ Fluoride supplements

___ Mouthwash

Do you ever use:

___ Cigarettes, cigar, pipe smoking, smokeless tobacco Frequency _____

Comments: _____

_____

To the best of my knowledge, the questions on these forms 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 my (or patient's) medical status and/or personal information.
I understand this office will see me and/or my family by appointments reserved for me and/or my family to minimize my waiting time and to maximize the efficiency of services rendered. I understand I will be notified of upcoming dental appointments with reminders and confirmations using Text, E-mail and US Mail services.
I agree to provide this office with a 24 hour notice if I am unable to keep an appointment reserved for me or my family, and understand a cancellation or missed appointment fee may be assessed if I fail to provide this notice.

Print Patient Name _____

_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

NGFD NORTH GARLAND
FAMILY DENTAL

# Reserved Appointments

We want to thank you for choosing us as your dental care provider. In order to provide you and our other patients with the best dental care, we see patients by reserved appointment. Because we take your dental care very seriously, and hope to have a long and mutually satisfying professional relationship, we ask that you make every effort to honor your reserved appointment times. Reserved appointment times are advantageous for our patients because they increase our care and efficiency by expediting your treatment and minimizing your waiting time in our office.

Please remember that we do not double book patients on our schedule. When you have a reserved appointment, this time has been reserved especially for you, and our providers plan and prepare in advance for your arrival. For our many patients who need the early morning or late afternoon appointments to minimize time away from work or school, these times have been reserved and held for you for up to 6 months in advance. In addition, our office sends out numerous appointment reminders and confirmations (email, post card, and text) to help you to keep your appointments.

Should you need to change a reserved appointment which was made at your last checkup (6 months ago), please contact us at least one week prior to your scheduled appointment, and for all other appointments scheduled more recently, we request 48 hours notice.

For broken or cancelled appointments without notice as stated above you will be assessed a broken appointment fee. After the third occasion, future appointments will only be reserved for you when you Pre-pay for your next appointment.

As a convenience, many families enjoy the privilege of bringing multiple family members for their dental care on the same day. When multiple family members are scheduled together on the same day, and the appointment is cancelled without adequate notice, a Broken Appointment fee will be assessed for each family member, and we will not be able to schedule multiple family members on the same day in the future.

We understand that schedules can be complicated and that emergencies do happen. As your dental care provider, we ask for your courtesy in contacting us as soon as possible to reschedule any reserved appointments. Thank you for your consideration of honoring and keeping Reserved Appointments, and we look forward to the opportunity to serve you and provide excellent dental care for you and your family for many years to come.

As a patient at North Garland Family Dental, I am aware of the Reserved Appointment Policy, and agree to its conditions.

Signature Date

NORTH GARLAND FAMILY DENTAL

# 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 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 10/22/14, 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 at the end of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Payment:** We may use and disclose your PHI and ePHI to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Disclosure:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**(a) Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your health information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $25.00 for the first 20 pages, then $0.15 each additional page. You may request an electronic copy of your patient records. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**(b) Right to Request Restriction of PHI:** You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters. Upon written request, you may elect to receive mailings from us in a closed envelope rather than by postcard.

## YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get electronic copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $25.00 for the first 20 pages, then $0.15 each additional page. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to request and receive an accounting of certain non-routine disclosures of your identifiable health information. We are required to maintain a log of these non-routine disclosures for a period of no less than six years beginning April 14, 2003. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**Breach Notification Requirements:** Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

## QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

**PRIVACY OFFICER:** Gary L.Peterick DDS **ADDRESS:** 1309 Beltline Rd., Suite A Garland, TX 75040 **TELEPHONE:** 972-530-7979 **FAX:** 972-759-9735

# Confidential Communication Agreement

Name of Patient: _____

I, the undersigned, authorize North Garland Family Dental to release my medical records TO, or to obtain FROM, the following (i.e. Insurance companies, previous dentist):

_____

List the FAMILY MEMBERS or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis or in case of emergency:
Name_____ Phone_____
Name_____ Phone_____

List the EMAIL ADDRESS to which we may send your private health information:
Email Address: _____
Alternate Email Address: _____

Print the TELEPHONE NUMBER where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions: Telephone Number: _____
May we send TEXT messages to this number? Yes_____ No _____
May we leave a message or VOICE MAIL to this number? Yes_____ No_____

To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out reimbursement of insurance benefits in connection with my insurance plan. I understand that this agreement remains in effect until revoked by me in writing.

Print Name Signature Date

.

# HIPAA Privacy Practices Acknowledgment

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in this office, and I will be offered a copy of any amended Notice of Privacy Practices.

Print Name Signature Date

If not signed by the patient, please indicate:
Relationship? ☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary of personal representative of deceased patient