

Market Heights Family Dental

Patient Name _____ Birthdate _____ Age _____
 Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ SS# _____ DL# _____
 Home Address _____ City _____ Zip _____
 Home Number (____) _____ Cell Phone (____) _____
 Email: _____ **Best way to contact you:** Cell Home Text Email

Employer Name and Address _____
 Occupation _____ Work # (____) _____
 Person Responsible for Account _____ Relationship _____
 Social Security # _____ Birthdate _____ Home # (____) _____
 Home Address (if different) _____ City _____ Zip _____
 Employer and address _____
 Occupation _____ Work # (____) _____
 Referred By _____ Physician _____
 Emergency Information _____
 (Name, Address, Telephone of a relative not living with you)

DENTAL INSURANCE INFORMATION (Primary)

SECONDARY INSURANCE INFORMATION

Insured's Name:		Insured's Name:	
Insured's DOB:		Insured's DOB:	
Insured's Employer:		Insured's Employer:	
Insurance Company:		Insurance Company:	
Group#	Phone#	Group#	Phone#

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependants is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance. I hereby authorize this office to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Patient/Guardian Signature _____ Date _____

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Please check any of the following problems that apply to you.		If you could whiten your teeth, would you do it? Yes/No	
- Sensitivity (hot, cold, sweet) Where? UR LR UL LL	<input type="checkbox"/>	Do you smoke or use chewing tobacco? How much? _____ For how long? _____	<input type="checkbox"/>
- Headaches, earaches, neck pain	<input type="checkbox"/>	If I could change my smile, I would:	<input type="checkbox"/>
- Jaw joint pain	<input type="checkbox"/>	-Make them whiter	<input type="checkbox"/>
- Teeth or fillings breaking	<input type="checkbox"/>	-Make them straighter	<input type="checkbox"/>
- Grinding or clenching teeth	<input type="checkbox"/>	-Close spaces	<input type="checkbox"/>
- Bleeding, swollen or irritated gums	<input type="checkbox"/>	-Replace black metal fillings with tooth colored restorations	<input type="checkbox"/>
- Loose, tipped or shifting teeth	<input type="checkbox"/>	-Repair chipped teeth	<input type="checkbox"/>
- Bad breath	<input type="checkbox"/>	-Replace missing teeth	<input type="checkbox"/>
Do you have or have you had any of the following?	<input type="checkbox"/>	-Replace old crowns that don't match	<input type="checkbox"/>
-Dentures	<input type="checkbox"/>	-Have a smile makeover	<input type="checkbox"/>
-Partial dentures	<input type="checkbox"/>	On a scale of 1 – 10, with 10 being the highest rating: – How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10 – Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10 – Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10	
-Braces	<input type="checkbox"/>		
-Periodontal (gum) treatments	<input type="checkbox"/>		
Please share the following dates: -Your last cleaning _____/_____/_____ -Your last oral cancer screening _____/_____/_____ -Your last complete X-Rays _____/_____/_____	<input type="checkbox"/>		
Name of Previous Dentist _____ City _____ ST _____ Phone # _____		What is the most important thing to you about your dental visit today? _____	
		What is the most important thing to you about your future smile and dental health? _____	

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer, Any Form, Tumor	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Venereal Disease	No	Yes
Heart Murmur (mitral valve prolapse)	No	Yes	HPV human papillomavirus	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids?	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin?				No	Yes
				When did the treatment end?	
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

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Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list any medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Please list any dietary or herbal supplements you are taking, and for what purpose:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

Women: Are you pregnant? No Yes
 If no, are you planning a pregnancy in the near future? No Yes
 Are you a nursing mother? No Yes
 Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle) No Yes
 Have you ever received a diagnosis of "high blood pressure"? No Yes
 What is your normal blood pressure? S /D Today: _____ / _____

Are you allergic or have you had a reaction to:

a. Local anesthetics	No	Yes
b. Penicillin or other antibiotics	No	Yes
c. Aspirin, Ibuprofen or Tylenol	No	Yes
d. Codeine, Valium [®] or other sedatives	No	Yes
e. Latex or Metals	No	Yes
f. Other (please specify) _____		

Alcohol, Drugs

Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed?	No	Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) _____ _____
Patient Signature Date

Doctor (Print Name) _____ _____
Doctor Signature Date

Market Heights Family Dental

Dental Insurance Policy

Whether you have purchased dental insurance on your own or your employer has provided it for you, you are fortunate to have it and we will go the extra mile to help you maximize your benefits provided by your specific plan. If you wish, we will also be glad to help you file your insurance forms which will save you considerable time and trouble. Your insurance company usually only pays a percentage of the fee, and this varies from plan to plan. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between us and the insurance company.

On rare occasions, a dental insurance plan will require a "predetermination" or "prior authorization" for treatment, though most insurance companies do not require this. If they do, we will be happy to submit a treatment plan to your insurance carrier at your request. In order for us to submit your form, we ask that you provide the following:

1. A copy of your insurance booklet or a copy of your insurance card.
2. A copy of a signed insurance form with the subscriber's birth date, social security number, group or ID number, and the name of employee, whichever is applicable.

I have read and understand the above.

Signature

Date

Market Heights 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 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 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 **June 1st, 2010**, and will remain in effect until we replace it.

We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. The revised Notice will apply to all of your health information. We may also revise this notice from time to time. If we make any material revisions to this Notice, we will provide you with a copy of the revised Notice which will specify the date on which such revised Notice becomes effective. We are required to abide by the terms of the Notice that is currently in effect. 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

A. Use and Disclosure for Treatment, Payment, and Health Care Operations

We must disclose your health information to you, as described in the Patient Rights section of this Notice. We also use and disclose health information about you for treatment, payment, and health care operations. For example:

- **Treatment:** We may disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Health care Operations:** We may use and disclose your health information in connection with our health care operations, including quality assessment and improvement activities, review of the competence or qualifications of health care professionals, evaluation of practitioner and provider performance, training programs, accreditation, certification, and licensing and credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or health care operations, 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 this Notice.

Disclosures To Your Family and Friends: We may disclose your health information to a family member, friend, or other person identified by you to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Disclosures To Persons Involved in Your Care: We may also use or 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, of your location, 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 use or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, and we will disclose only health information that is directly relevant to the person's involvement in your health care. 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, postcards, letters).

Patient-Related Communications: We may use or disclose your health information to provide patient-related communications such as intraoral photography, "no cavity club" for children, and telephoned-in prescriptions.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

B. Use and Disclosure for the Public Need

In particular situations involving the public need, we may disclose your health information without obtaining your authorization. Those situations include the following circumstances:

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

Public Health Activities: We may disclose your health information to authorized public health officials so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury, or disability.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections, as well as civil, administrative or criminal investigations, proceedings, or actions.

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.

Product Monitoring, Repair and Recall: We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes: We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

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Law Enforcement: We may disclose your health information to law enforcement officials for certain reasons including to comply with court orders or laws that we are required to follow, and to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person.

To Avert a Serious and Imminent Threat to Health or Safety. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. In such cases, we will only share your information with someone able to help prevent the threat.

National Security: We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to military authorities the health information of Armed Forces personnel under certain circumstances. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

C. Partially De-Identified Health Information

We may use and disclose "partially de-identified" health information about you for public health and research purposes, or for business operations, if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. If we maintain your health information in electronic format, you may request a copy of your information in electronic format and we will charge you no more than our cost of preparing the materials. If we maintain your information in paper files, you may request photocopies or copies in another format. We will use the format you request unless we cannot practically and reasonably do so. If you request an alternative format, we may charge a cost-based fee for providing your health information in that format. 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.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years or such shorter time as you may specify. That accounting would not include disclosures made for the purposes of treatment, payment, or health care operations, unless we maintain your health record electronically, in which case, after January 1, 2011, we may need to provide you with an accounting of treatment, payment, or health care operations disclosures for no more than 3 prior years, but not including any treatment, payment, or health care operations disclosures prior to January 1, 2011. 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.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. If we agree to your request, we will abide by our agreement except in an emergency situation. However, we are not required to agree to these additional restrictions, except that we must agree to a request that we restrict disclosure of your information to a health plan for purposes of payment or health care operations if the information pertains solely to a health care item or service that you have paid for out of pocket and in full.

Alternative Communication: 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 a satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment of Health Information: 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.

Notification of Breach of Unsecured Health Information: Our policy is to encrypt our electronic files containing your health information so as to protect the information from those who should not have access to it. If, however, for some reason we experience a breach of your unencrypted health information, we will notify you of the breach.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you have the right to request a paper copy of this Notice. You may make such a request by writing to the address provided at the end of this Notice.

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 alternative locations, 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 INFORMATION
Fossum Management
2534 Blue Meadow Drive
Temple, Texas 76502
254.778.3900

Market Heights Family Dental
Acknowledgement of Receipt
Notice of Privacy Practices

I, _____ (patient's name) have received a copy of this office's Notice of Privacy Practices form.

Patient Name

Patient/Guardian Signature*

Date

***You may refuse to sign this form.**

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other – please specify

Market Heights Family Dental
HIPPA Release of Information

I _____ (patient) authorize the release of information including the diagnosis records; examination rendered to me and claims information. This information may be released to:

- Spouse: _____
- Child(ren): _____
- Other: _____
- INFORMATION IS NOT TO BE RELEASED TO ANYONE.

This HIPPA Release of Information will remain in effect until terminated by me in writing. _____(Pts. initials)

How would you like to be contacted?

Please call:

- Home# _____
- Work # _____
- Cell # _____

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking to return call
- Other: _____

Patient/Guardian Signature

Date

Market Heights Family Dental
Photographic / Media Consent Form

INFORMATION: I hereby consent to the collection and use of my personal images by photography or video recording. I acknowledge these may be used on the Fossum Dental Group websites and social media mediums, in newsletters and publications. I also understand that my consent can be withdrawn at any time in writing to:

Market Heights Family Dental
201 East Central Texas Expressway, #500
Harker Heights, Texas 76522

CONSENT FORM

I

(Name of person giving consent & parent/guardian if under 18 years of age)

Consent to the use of photographs or video footage for use on the Fossum Dental Group website and social media mediums, in newsletters and publications. I further understand that this consent may be withdrawn by me at any time, upon written notice.

I **give** this consent voluntarily.

Patient Signature

Signature of parent/guardian < 18

Date

I **decline** consent.

Patient Signature

Signature of parent/guardian < 18

Date