Pristine Family Dentistry

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PATIENT INFORMATION

Patient's Name: _____
Last First MI (Preferred)

Address: _____
Street City State Zip code

Cell Phone: _____ Home Phone: _____ DOB: _____ SSN: _____

Gender: ☐ Male ☐ Female ☐ Unknown Married: ☐ Yes ☐ No Email: _____

Preferred contact method ☐Cell Phone ☐Home Phone ☐ Email ☐ Text

Preferred contact method for recall/confirmations ☐Cell Phone ☐Home Phone ☐ Email ☐ Text

If the patient is a minor, give parent's or guardian's name: _____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Married: ☐ Yes ☐ No

Address: _____

Your relationship to patient: ☐Self ☐ Spouse ☐ Child Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ DOB: _____ Driver License #: _____

INSURANCE INFORMATION

Insurance #1

Policy Holder Name: _____ SSN: _____

Insurance Company: _____ Group #: _____ ID #: _____ Union Local #: _____

Insurance Company Address: _____ Insurance Company Phone: _____

Policy Holder's Employer: _____ Do you have dual coverage: ☐ No ☐ Yes

Insurance #2

Policy Holder Name: _____ SSN: _____

Insurance Company: _____ Group #: _____ ID #: _____ Union Local #: _____

Insurance Company Address: _____ Insurance Company Phone: _____

Policy Holder's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Home Phone: _____ Cell Phone: _____ Relationship: _____

_____ _____ _____

Signature (parent's signature if patient is a minor) Printed Name Date

9601 N. Beach St. Ste#101 Fort Worth, TX 76244 – (P) 817-741-6041
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Last Name: _____First Name:_____ DOB:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment, activities and healthcare operations of the uses and disclosures we may make of your protected health information and other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Officer: Office Coordinator/ Practice Manager
Address 9601 N Beach St. Ste# 101, Fort Worth, TX 76244
Phone: 817-741-6047 / FAX 817-741-6049

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent Form I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and health care operations.

_____ _____ _____

Patient or Parent or Guardian signature | Printed Patient's Name | Date

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Last Name: _____ First Name: _____ Birthdate: _____

Are you currently under physician's care?	☐Yes	☐No	If yes, please explain: _____
Have you had a serious head or neck injury?	☐Yes	☐No	If yes, please explain: _____
Do you use controlled substances?	☐Yes	☐No	If yes, please explain: _____
Have you been hospitalized or had a major operation?	☐Yes	☐No	If yes, please explain: _____
Do you use tobacco?	☐Yes	☐No	If yes, please explain: _____
Are you on special diet?	☐Yes	☐No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux	☐Yes	☐No	If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐Yes	☐No	If yes, please explain: _____
Are you taking any medications, pills or drugs?	☐Yes	☐No	If yes, please explain: _____

Current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Women: Are you…

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Latex
☐ Metal ☐ Sulfa Drug ☐ Local Anesthetics ☐ Other. _____

Check if you have had any of the following conditions:

☐AIDS/HIV Positive	☐Congenital Heart	☐Frequent Headaches	☐Irregular Heartbeat	☐Scarlet Fever
☐Alzheimer's Disease	☐Convulsions	☐Genital Herpes	☐Kidney Problems	☐Shingles
☐Anaphylaxis	☐Cortisone Medication	☐Glaucoma	☐Leukemia	☐Sickle Cell Disease
☐Anemia	☐Diabetes	☐Hay Fever	☐Liver Disease	☐Sinus Trouble
☐Angina	☐Disorder	☐Heart Attack/Failure	☐Low Blood Pressure	☐Spina Bifida
☐Arthritis/Gout	☐Dizziness	☐Heart Murmur	☐Lung Disease	☐Stomach/Intestinal Disease
☐Artificial Heart Valve	☐Drug Addiction	☐Heart Pacemaker	☐Mitral Valve Prolapse	☐Stroke
☐Artificial Joint	☐Easily Winded	☐Heart Trouble/Disease	☐Pain in Jaw Joints	☐Swelling of Limbs
☐Asthma	☐Emphysema	☐Hemophilia	☐Parathyroid Disease	☐Thyroid Disease
☐Blood Disease	☐Epilepsy or Seizures	☐Hepatitis A	☐Psychiatric Care	☐Tonsillitis
☐Blood Transfusion	☐Excessive Bleeding	☐Hepatitis B or C	☐Radiation Treatments	☐Tuberculosis
☐Breathing Problems	☐Excessive Thirst	☐Herpes	☐Recent Weight Loss	☐Tumors or Growths
☐Bruise Easily	☐Fainting Spells	☐High Blood Pressure	☐Renal Dialysis	☐Ulcers
☐Cancer	☐Frequent Cough	☐Hives or Rash	☐Rheumatic Fever	☐Venereal Disease
☐Chemotherapy	☐Frequent Diarrhea	☐Hypoglycemia	☐Rheumatism	☐Yellow Jaundice
☐Chest Pains				

Have you had any serious illness not listed above? ☐Yes ☐No If yes, please explain: _____

To my best knowledge, the questions on this form have been accuracy 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 medical status.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

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Personal dental needs survey

Last Name:_____ First Name:_____ Date:_____

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care. (1 = most important)

____Preventative Dental Health Care ____Freedom from pain ____Other
____Excellence and quality of Service ____Cost and Affordability

Please rate on a scale of 1-3 what a dentist must do to gain your confidence.

____Show me what he/she is doing or needs to do so I can clearly understand what is happening.
____Listen to my concerns and explain thoroughly the procedures to be performed.
____Make sure I feel comfortable and informed at all times.

Please check the level of fear you have about your dental visits (10 being the greatest fear).

1 2 3 4 5 6 7 8 9 10

I would like to know about these options available to me for maximizing my comfort and my experience during my visit. Check all that apply.

____ Music or Movie with headphones (Please list your preferred music type) _____
____Nitrous Oxide ____Patient Education Material ____Neck Wraps
____Patient Education Material ____Sedative Medications ____Other _____

Are you concerned about the following? (Mark Y-yes or N-no)

____Exiting Discomfort ____Appearance of my smile ____Mouth order
____Prevention of decay ____Whitening your teeth ____Other:_____
____Replacing old silver fillings ____Recurring or untreated gum disease

Please check one answer for each of the following:

When discussing my treatment plan, I prefer: When evaluating my smile, it is more important:

____ The big picture ____ Detail by detail ____ What I see ____ What others see

TMJ History (Please circle)

Have you ever had or been diagnosed with a problem with either Jaw Joint?	Yes	No
Does your jaw click, pop or make noise when you open and close?	Yes	No
Do you ever have pain or tenderness in your jaw joint when you open, close or chew?	Yes	No
Has your jaw ever locked open or closed?	Yes	No
Do you have frequent headaches? If so, how often?	Yes	No
Do you clench or grind your teeth, or ever been told that you do?	Yes	No
Have you ever had trauma to your chin or jaw?	Yes	No

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Financial Agreement

Last Name: _____ First Name: _____ Birthdate:_____

Thank you for choosing Pristine Family Dentistry as your dental healthcare provider. We are dedicated to providing the highest quality of care possible. We are also committed to providing our patients clear and straightforward information regarding their financial responsibilities. The following is a statement of our Financial Terms that we require you to read and sign before treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, and most major credit cards. Also, we reserve the right to charge for appointments cancelled or broken without 48 hours advance notice.

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and co-payments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL**. Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection of the balance.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

_____ _____

Signature of Responsible Party Date

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Regarding appointments

Last Name:_____ First Name: _____ DOB:_____

Your time is very important and so is ours. When you have an appointment with us, our commitment to you is:

- We always try to make appointments that are convenient for you.
- We will not ask you to make a schedule change unless it is an extreme emergency or of a potential benefit to you.
- We will always be respectful of your personal time and will make every effort to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that we reserve chair time just for you when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved time as it is scheduled. Please give our office 48 hours(or more, if possible with the exception of extreme personal emergency) notice if you need to change your appointment or a fee will be assessed to your account based on the amount of time scheduled, **at the rate of $100 per hour.**

Please keep us informed of any changes to your health information and medications as well as your address, phone, email or insurance information so that we may service you in the best possible manor.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

_____ _____ _____

Patient or Parent or Guardian signature | Printed Patient's Name | Date

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Photo Release Form

Last Name: _____ First Name: _____ DOB: _____

Cat-Nhan Do, DDS.

Pristine Family Dentistry

9601 N Beach St. Suite 101.

Fort Worth, TX 76244

Permission to Use Photographs

Subject: Dental Photography.

I grant Dr. Cat-Nhan Do, its representatives, and team members the right to take photographs of me, my mouth and teeth in connection with the above- identified subject. I authorize Dr. Cat-Nhan Do, its assigns, and transferees to copyright, use, and publish the same in print and/or electronically.

I agree that Dr. Cat-Nhan Do may use such photographs of me with my name for any lawful purpose; including for example, such purpose as educational lecturing, illustration, advertising, and Web content.

I have read and understand the above.

_____	_____	_____
Patient or Parent or Guardian signature	Printed Patient's Name	Date

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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 **March 1st, 2017**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. 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 listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare 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.

To Your Family and Friends: 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 a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may 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, 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 incapacity or 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.

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

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

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. 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge 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 6 years but not before **March 1st, 2017.** 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 satisfactory explanation 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: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 Officer: Office Coordinator/ Practice Manager

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