TOWNE DENTAL
& ORTHODONTICS

You may fax this form to:
936-372-1006

## PATIENT REGISTRATION

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==== Patient information ==========

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____

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

Date of Birth: _____ Soc Sec: _____ Drivers Lic: _____

Patient is: ☐ Policy Holder ☐Responsible Party

==== Responsible party Information ===========

Address: _____ Address 2: _____

City, State, Zip: _____

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

Occupation: _____ Place of employment: _____

Date of Birth: _____ Age: _____ Soc. Sec: _____ Drivers Lic:_____

E-mail: _____

### DENTAL HISTORY

1. Purpose of Initial Visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
6. When was the last time your teeth were cleaned? _____
7. Have you made regular visits? ..... YES NO
   How often: _____
8. Have you lost any teeth or have any teeth been removed? ..... YES NO
   Why? _____
9. Have they been replaced? ..... YES NO
10. Have you ever had any problems or complications with previous dental treatment? ..... YES NO
11. Do you clench or grind your teeth? Does your jaw clench or pop? ..... YES NO
12. Have you experienced any pain or soreness in the muscles around your face or around your ears? ..... YES NO
13. Do you have frequent headaches, neck aches or shoulder aches? ..... YES NO
14. Does food get caught in your teeth? ..... YES NO
15. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
16. Do your gums bleed or hurt? ..... YES NO
17. How often do you brush your teeth? _____ When? _____
18. Do you use dental floss? ..... YES NO
19. Are any of your teeth loose, tipped, shifted, or chipped? ..... YES NO
20. How do you feel about your teeth in general? _____
21. Are you interested in whitening your teeth? ..... YES NO
22. Do you have any questions or concerns? ..... YES NO

**How were you referred to/found our office?** _____

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## MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a 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 If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates? ☐Yes ☐No _____

*Women: Are you*

Are you on a special diet? ☐Yes ☐No Pregnant/Trying to get pregnant? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No Nursing? ☐Yes ☐No

Do you use controlled substances? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ☐ Yes ☐ No | Cortisone Medicine ☐ Yes ☐ No | Hemophilia ☐ Yes ☐ No | Recent Weight Loss ☐ Yes ☐ No |
| Alzheimer's Disease ☐ Yes ☐ No | Diabetes ☐ Yes ☐ No | Hepatitis A ,B or C ☐ Yes ☐ No | Renal Dialysis ☐ Yes ☐ No |
| Anaphylaxis ☐ Yes ☐ No | Drug Addiction ☐ Yes ☐ No | High Cholesterol ☐ Yes ☐ No | Rheumatic Fever ☐ Yes ☐ No |
| Anemia ☐ Yes ☐ No | Easily Winded ☐ Yes ☐ No | Herpes ☐ Yes ☐ No | Rheumatism ☐ Yes ☐ No |
| Angina ☐ Yes ☐ No | Emphysema ☐ Yes ☐ No | High Blood Pressure ☐ Yes ☐ No | Scarlet Fever ☐ Yes ☐ No |
| Arthritis/Gout ☐ Yes ☐ No | Epilepsy or Seizures ☐ Yes ☐ No | Hives or Rash ☐ Yes ☐ No | Shingles ☐ Yes ☐ No |
| Artificial Heart Valve ☐ Yes ☐ No | Excessive Bleeding ☐ Yes ☐ No | Hypoglycemia ☐ Yes ☐ No | Sickle Cell Disease ☐ Yes ☐ No |
| Artificial Joint ☐ Yes ☐ No | Excessive Thirst ☐ Yes ☐ No | Irregular Heartbeat ☐ Yes ☐ No | Sinus Trouble ☐ Yes ☐ No |
| Asthma ☐ Yes ☐ No | Fainting Spells/Dizziness ☐ Yes ☐ No | Kidney Problems ☐ Yes ☐ No | Spina Bifida ☐ Yes ☐ No |
| Blood Disease ☐ Yes ☐ No | Frequent Cough ☐ Yes ☐ No | Leukemia ☐ Yes ☐ No | Stomach/Intestinal Disease ☐ Yes ☐ No |
| Blood Transfusion ☐ Yes ☐ No | Frequent Diarrhea ☐ Yes ☐ No | Liver Disease ☐ Yes ☐ No | Stroke ☐ Yes ☐ No |
| Breathing Problem ☐ Yes ☐ No | Frequent Headaches ☐ Yes ☐ No | Low Blood Pressure ☐ Yes ☐ No | Swelling of Limbs ☐ Yes ☐ No |
| Bruise Easily ☐ Yes ☐ No | Genital Herpes ☐ Yes ☐ No | Lung Disease ☐ Yes ☐ No | Thyroid Disease ☐ Yes ☐ No |
| Cancer ☐ Yes ☐ No | Glaucoma ☐ Yes ☐ No | Mitral Valve Prolapse ☐ Yes ☐ No | Tonsillitis ☐ Yes ☐ No |
| Chemotherapy ☐ Yes ☐ No | Hay Fever ☐ Yes ☐ No | Osteoporosis ☐ Yes ☐ No | Tuberculosis ☐ Yes ☐ No |
| Chest pain ☐ Yes ☐ No | Heart Attack/Failure ☐ Yes ☐ No | Pain in Jaw Joints ☐ Yes ☐ No | Tumors or Growths ☐ Yes ☐ No |
| Cold Sore/Fever Blisters ☐ Yes ☐ No | Heart Murmur ☐ Yes ☐ No | Parathyroid Disease ☐ Yes ☐ No | Ulcers ☐ Yes ☐ No |
| Congenital Heart Disorder ☐ Yes ☐ No | Heart Pace Maker ☐ Yes ☐ No | Psychiatric Care ☐ Yes ☐ No | Venereal Disease ☐ Yes ☐ No |
| Convulsions ☐ Yes ☐ No | Heart Trouble/Disease ☐ Yes ☐ No | Radiation Treatments ☐ Yes ☐ No | Yellow Jaundice ☐ Yes ☐ No |

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

Comments: _____

_____

To the best of my knowledge, the questions on this form 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 medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: _____ Email: _____

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

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

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign the 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 of other important matters about your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.

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 our 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 Person: **Dr. Paula Wood Herber**
Telephone: **936-372-1177** Fax: **936-372-1006**
Email: **info@townedentalandortho.com**
Address: **31303 FM 2920 Road, Suite B, Waller, Texas**

**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.

**SIGNATURE**

I, _____ have had full opportunity to read and consider the contents or 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, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

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## Revocations of Consent- Do not sign below unless you do not want to be seen at our office.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:

**IF YOU SIGN HERE WE CAN NOT SEE YOU IN THE OFFICE.**

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*You May Refuse to Sign This Acknowledgement*

I, _____have received a copy of this office's Notice of Privacy Practices.

_____ _____

***Signature*** ***Date***

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**Right of Access Form for Family Member/Friend**

Please list any persons other than yourself that we may discuss your information with: _____

Name of the Individual Giving this Authorization: _____

Signature of the Individual Giving this Authorization: _____ Date_____

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**FINANCIAL POLICY**

You are legally responsible for payment on any treatment received at Towne Dental & Orthodontics. Insurance benefits are not a guarantee and you are financially responsible for any fees or portion that insurance does not cover. In addition, a fee may be charged for appointments cancelled with less than 48 hours advanced notice.

Accounts with an unpaid balance will acquire a $25.00 monthly fee. Any patient that is sent to collections for an unpaid balance will have a collection fee of 35% added to their balance. For any arranged payment plans that become delinquent a $25 fee will be added to each late payment until payments are current.

_____ _____

***Signature*** ***Date***

**CREDIT CARD AUTHORIZATION**

For your convenience and ease of billing, we recommend that you leave a credit card on file for any unpaid fees not paid by insurance. Dental Insurance plans have become so complex that no dentist can estimate coverage exactly. When we receive an insurance payment, we notify you by phone of any additionally owed payment. In the event that we haven't heard from you within 48 hours, we will automatically bill your card the owed copayment.

I, _____ authorize **Towne Dental & Orthodontics** to charge my credit card to cover any unpaid fees not paid by insurance.

Card Type: _____

Credit Card #:_____ Exp date: _____

CV Code: _____ (three digit code on back of card- Amex uses a 4 digit code)

_____ _____

Cardholder's Signature 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 **February 24, 2011**, 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 the 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. The 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 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 you 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 ruled 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.

## 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 **$3.00** for each page, **$8.00** per hour of 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 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. All requests need to allow **14 days** for the records to be processed and made available. 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 February 24, 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.

**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 make 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 Person: **Dr. Paula Wood Herber**
Telephone: **936-372-1177** Fax: **936-372-1006**
Email: **info@townedentalandortho.com**
Address: **31303 FM 2920 Road, Suite B, Waller, Texas**