



We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name _____
Last First MI (Preferred)
 Birthdate _____ SS# _____ DL# _____ Gender: M F Married: Y N
 Work Phone _____ Wireless Phone _____ Email _____

If patient is under 18 yrs, please also complete the following:

Guarantor Name _____
Last First MI (Preferred)
 Birthdate _____ SS# _____ DL# _____ Gender: M F Married: Y N
 Work Phone _____ Wireless Phone _____ Email _____

Preferred contact method Hm Phone Wk Phone Wireless Ph Email
 Student status if dependent over 19 (for ins) Nonstudent Fulltime Part time
 How did you hear about us? (Please be specific so we can thank them!) _____

ADDRESS AND HOME PHONE

Check box if same for entire family

Address _____
 Address 2 _____
 City _____ State _____ Zip _____
 Home Phone _____

INSURANCE POLICY 1

Patient relationship to subscriber: Self Spouse Child
 Sub. Name _____ Sub.ID # _____ Sub.DOB _____
 Insurance Company _____ Phone _____
 Employer _____ Group Name _____ Group # _____

INSURANCE POLICY 2

Patient relationship to subscriber: Self Spouse Child
 Sub. Name _____ Sub.ID # _____ Sub.DOB _____
 Insurance Company _____ Phone _____
 Employer _____ Group Name _____ Group # _____

Comments: _____

Please complete reverse side.

FINANCIAL AGREEMENT

- * For my convenience, this office may release my information to my insurance, and receive payment directly from them.
- * We ask that you inform us at least 24 hours notice to reschedule your appointment. No shows are charged \$25.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * Treatment plans may change, and I will be responsible for the work actually done.

Signature _____ Date _____

MEDICAL HISTORY

Name of Medical Doctor: _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking:

- None
- _____
- _____
- _____

Check medications or drugs you are allergic to:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Codeine/ Other Narcotics | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Latex Rubber | <input type="checkbox"/> Other: _____ |

Check any medical conditions you may have:

- | | | |
|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement, Date of: _____ |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney/Bladder Trouble |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Anemia/Leukemia | <input type="checkbox"/> Fainting Spells/Seizures | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Frequently Dry Mouth/Sjogren | <input type="checkbox"/> Persistent Diarrhea |
| <input type="checkbox"/> Blood Clotting Problems | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cancer/Tumor or Growth | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Chest Pain Upon Exertion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Damage Heart Valve | <input type="checkbox"/> Hives/Skin Rash | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other: _____ | | |

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? Yes / No

New patients:

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Name (printed)

Date

Patient/Guardian Signature

Dental Service Agreement

I hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate. I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Patient/Guardian Name (printed)

Date

Consent for Photo Release

I grant Eternity Dental the right to take photographs of me and my family. I agree that Eternity Dental may use such photographs with or without my name for lawful purposes, including clinical chart reviews, communication with dental laboratories, communication with other dental specialists and professionals, illustration, advertising and web content.

Should I wish to send these photographs to other dental care providers, I shall formally request them in writing as is required by the State Dental Board of Texas for transfer of records

Patient/Guardian Name (printed)

Date

Health Insurance Portability & Accountability Act-HIPAA

I, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (next page).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Eternity Dental has the right to change its Notice of Privacy Practices from time to time and that I may contact Eternity Dental at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Eternity Dental restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Eternity Dental is not required to agree to my requested restrictions, but if Eternity Dental does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Eternity Dental has taken action relying on this consent.

By signing your first name and last name, you certify that you have received and read this organization Notice of Privacy Practices (next page).

Patient/Guardian Name (printed)

Date

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative

means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).