

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female I prefer to be called \_\_\_\_\_  
S.S.N. / S.I.N. \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Email Address \_\_\_\_\_  
Patient Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Sports/Hobbies \_\_\_\_\_  
Patient's Present Weight \_\_\_\_\_ lbs Height \_\_\_\_\_ ft. \_\_\_\_\_ in.  
Custodial Parent(s) or Guardian(s) \_\_\_\_\_  
Phone (if different than patient's) \_\_\_\_\_ Cell \_\_\_\_\_  
Address (if different than patient's) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PREVIOUS DENTIST INFORMATION

Name of Patient's Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason \_\_\_\_\_  
Name of Patient's Physician(s) \_\_\_\_\_  
Phone Number(s) \_\_\_\_\_  
Primary Physician's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date Last Seen \_\_\_\_\_ Reason \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION *(If Not Patient)*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address (if different than patient's) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (if different than patient's) \_\_\_\_\_ S.S.N. / S.I.N. \_\_\_\_\_  
Employer \_\_\_\_\_ Years with Employer \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Coverage for Dental Treatment?  Yes  No Coverage for Orthodontic Treatment?  Yes  No  
Primary Policy Holder's Name \_\_\_\_\_ S.S.N. / S.I.N. \_\_\_\_\_  
Birth Date \_\_\_\_\_ Employed By \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_  
Secondary Policy Holder's Name \_\_\_\_\_ S.S.N. / S.I.N. \_\_\_\_\_  
Birth Date \_\_\_\_\_ Employed By \_\_\_\_\_  
Dental Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_  
Medical Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

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 medication 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 If yes, what? \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes, what? \_\_\_\_\_
- Are you on a special diet?  Yes  No If yes, what? \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes, what? \_\_\_\_\_
- Do you use controlled substances?  Yes  No If yes, what? \_\_\_\_\_

Are you a woman who is...  Pregnant/Trying to get pregnant  Nursing  Taking oral contraceptives

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Other \_\_\_\_\_
- Metal  Latex  Sulfa Drugs  Local Anesthetics  No Known Allergies

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

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

Have you ever had any serious illness not listed above?  Yes  No If yes, \_\_\_\_\_

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 \_\_\_\_\_

**Effective date: October 1, 2018**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with **Glasscock Family Dentistry**. This information is called “protected health information” (i.e., name, address, phone, etc.) that may identify you and relate you to your past, present or future physical or mental health condition and related healthcare services.

**Glasscock Family Dentistry** is required by law to maintain the privacy of protected health information and to follow the terms of this notice. This notice describes certain patient rights and how we use and disclose your protected health information to provide your treatment, obtain payment for services, receive and manage our health care operations and for other purposes that are permitted or required by law.

This notice has been drafted to be consistent with what is known as the Privacy Rule (45 CFR Parts 160 and 164) and any of the terms not defined in this notice should have the same meaning as they have in the Privacy Rule. We are also required to comply with any federal or state laws that impose stricter standards than the uses and disclosures described in this notice.

We reserve the right to change the terms of our notice, at any time. New versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised notice of privacy practices.

## **YOUR RIGHTS UNDER THE PRIVACY RULE**

You have the following rights regarding protected health information that we maintain about you. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this notice of privacy practices by requesting a copy from our front desk at **615-371-8009**. You have the right to obtain a paper copy of this notice at any time, even if you have already received an electronic notice.

You have the right to authorize other uses and disclosures. This means we will not use or disclose your protected health information other than as specified in this notice, unless you authorize the use or disclosure in writing. You may revoke an authorization at any time, in writing, except to the extent that our office has taken an action in reliance on the use or disclosure indicated in the authorization.

To exercise any of the rights below, you must submit a written request to our privacy manager at the address listed above.

You have the right to designate a personal representative. This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is used to make decisions about you, such as health and billing records. Your request may be denied for certain reasons permitted by applicable law.

You have the right to request a restriction of your protected health information. This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of privacy practices. We may deny your request for a restriction.

You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted and specify information on how payment will be handled.

You may have the right to have us amend your protected health information. This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request an accounting of certain disclosures. This means that you may request a listing of disclosures of protected health information that we have made, except for disclosures made for purposes of treatment, payment, health care operations or for other purposes excluded from the accounting requirement. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

## COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our front desk of your complaint at 615-371-8009. You will not be penalized for filing a complaint.

## HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected information, consistent with the requirements of applicable law. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed.

**For Treatment** – We may use protected health information to provide you with health care treatment or services. We may disclose your protected health information for purposes of treatment, which includes providing, coordinating, or managing your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions.

**For Payment** – We may use or disclose your protected health information to obtain payment for our services. This may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services providing to you for dental necessity, and undertaking utilization review activities.

**For Health Care Operations** – We may use or disclose your protected health information in order to support the business activities of our practice. Health care operations include, but are not limited to, business planning and development, quality assessment and improvement, dental review arranging for legal services and auditing functions. It also includes education, provider credentialing, certification and underwriting, rating, or other insurance related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievances procedures, due diligence in connection with the sale or transfer of assets and creating de-identified information. We may also call you by name in the waiting room when your dentist is ready to see you.

**For Treatment Alternatives and Appointment Reminders** – We may use or disclose your protected health information to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. We may contact you to provide information about health related benefits and services offered by our office.

**To Others Involved in Your Dental Care and for Disaster Relief Purposes** – With your consent, we may disclose to a member of your family, a relative, or close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your dental care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. Further, we may use or disclose your protected health information to disaster relief agencies so they may assist in notifying those involved in your care of your location and general condition. If you are not present or able to agree or object in these rules or disclosures, then we may, using professional judgment, determine whether the disclosure is in the best interest. In this case, only the protected health information that is relevant to your dental care will be disclosed.

**As Required by Law** – We may use or disclose your protected health information to the extent that law requires the use or disclosure, including when disclosure is required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Privacy Rule.

**For Public Health** – We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

**For Communicable Diseases** – We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**For Health Oversight** – We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

**In Case of Abuse or Neglect** – We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information.

**For Legal Proceedings** – We may disclose protected health information in the course of any judicial or administrative proceedings in response to an order of the court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**To Law Enforcement** – We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

**To Coroners, Medical Examiners and Funeral Directors** – We may disclose protected health information to a coroner or medical examiner for identification purposes, determining causes of death for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to funeral directors, as authorized by law, in order to permit the funeral director to carry out their duties.

**For Organ, Eye or Tissue Donation** – We may use or disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

**To Avert a Serious Threat to Health or Safety** – We may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public. We may also disclose protected health information if it is necessary for the law enforcement authorities to identify or apprehend an individual.

**For Military Activity and National Security** – When the appropriate conditions apply, we may use or disclose protected health information of individuals who are armed forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the department of veterans affairs of your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military service. We may also release protected health information about you to authorized federal officials for intelligence, counterintelligence, to provide protection to the President, other authorized persons or foreign heads of state, to conduct special investigations and for other national security activities.

**For Worker's Compensation** – We may disclose your protected health information as authorized to comply with worker's compensation laws and other similarly legally established programs.

**When an Inmate** – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**For Research** – Under certain circumstances, we may use and disclose protected health information about you for research purposes. All research projects, however, are subject to a special approval process. With your consent, we may disclose protected health information about you under certain conditions to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the protected health information they review does not leave our facility.

**Business Associates** – We contract with individuals and entities, referred to as Business Associates, to perform various functions on our behalf or to provide types of services described in this notice. In order for Business Associates to perform their functions or services, we may disclose protected health information to them, but only after they have agreed in writing to safeguard the information. Examples of Business Associates may include our billing company.

# Acknowledgement of Receipt of Notice of Privacy Practices

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_ (please print) have been offered a copy of **Glasscock Family Dentistry's Notice of Privacy Practices**. I consent to Glasscock Family Dentistry using and disclosing my protected health information for purposes of treatment, payment and health care operations and other purposes listed under the "How We May Use or Disclose Protected Health Information" section of the Notice of Privacy Practices, consistent with requirements of applicable law. A copy of Glasscock Family Dentistry's Notice of Privacy Practices is available both in our office, as well as online at [GlasscockFamilyDentistry.com](http://GlasscockFamilyDentistry.com).

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

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## OFFICE USE ONLY BELOW THIS LINE

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We attempted to obtain written acknowledgment of Receipt of our Notice of Privacy Policies, but the Acknowledgment could not be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining acknowledgment
- An emergency situation prevented us from obtaining the acknowledgment
- Other (Please specify)

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# Cancellation/No Show Policy for Dental Appointments

## 1. CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seeming “full” appointment book.

***If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$50 fee. This will NOT be covered by your insurance company.***

## 2. SCHEDULED APPOINTMENTS

We understand that delays can happen however we must try to keep the other patients and doctor on time.

***If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.***

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Print Name of Patient, Parent or Guardian

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Signature of Patient, Parent or Guardian

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Date