



PATIENT INFORMATION

Patient's Name _____	DOB: _____	Marital Status: _____
If Minor, Parent's Name _____	Emergency Contact Name & Phone #: _____	
Email _____	Cell phone # _____	Other phone # _____
Address _____	City _____	State _____ Zip _____
Your Social Security#: _____	Employer _____	Occupation _____
Whom may we thank for referring you to our office? _____		
INSURANCE INFORMATION: <input type="checkbox"/> Not Covered by Dental Insurance Dental Insurance Co. _____ Group # _____		
Member ID# _____	Subscribers name: _____	Secondary insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Dental Insurance Co _____	Secondary Insurance ID# _____	
Secondary Group # _____	Secondary Subscriber name and DOB: _____	
Secondary Subscriber Social Security # _____		

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart defect
- Rheumatic fever or rheumatic heart disease
- Artificial joint or valve
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizures, or fainting spells
- Emotional condition
- Arthritis
- Herpes or cold sores
- AIDS or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorders
- Abnormal bleeding after extractions, surgery, or trauma
- Hayfever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke or use chewing tobacco? yes no

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics ("Novocain")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives, or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medicine
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medicine
- Other: _____

Women:

- May be pregnant
Expected delivery date: _____
- Taking hormones or contraceptives

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

Please add anything else you would like us to know about: _____

Signature of patient (or parent) _____ Date _____



We are glad you have chosen **Pure Smiles** to provide you with excellent dental care. Once you have scheduled an appointment with us, that time is reserved exclusively for you!

In order to successfully care for all of our patients, we need to be able to rely on these scheduled appointments. We strive to be on time for your scheduled appointment, and ask you to give us the courtesy of calling if you are unable to keep your appointment. By doing so, you give us the ability to treat and care for patients who would like the time previously scheduled.

If you miss your appointment you also compromise your care.

We would like to remind you of our office's policies regarding miss appointments*.

Please kindly give us **2 business days (48 hours)** notice in advanced if you are unable to keep your scheduled appointment time. **Otherwise, a \$50 missed appointment fee will be charged.**

You have the right to contest this fee.

Please contact our office manager, Ana Ibarra, at (281)-647-PURE (7873).

Signature of Patient (or Guardian if under the age of 18)

Date

Printed Patient Name

***A missed appointment is when you fail to show up for the scheduled appointment or make a phone call to cancel within 2 business days.**



AUTHORIZATION FOR SIGNATURE ON FILE AUTHORIZATION OF PAYMENT/RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefits plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay towards your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your employee benefits director can usually help you become familiar with your plan and its restrictions and our office will assist you in maximizing your benefits.

OUR RESPONSIBILITIES

1. Use current American Dental Assoc. coding for correct reporting of procedures.
2. Accept Direct Payment from your carrier and keep track of balance.
3. If necessary re-file your insurance a second time within a 60 day period.

YOUR RESPONSIBILITIES

1. To pay fees not covered by your plan at the time of treatment.
2. To provide our office with necessary information concerning your insurance coverage to allow correct filing of claims.
3. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment but we do not have the power to make your plan pay.
4. To pay any account balance not paid by insurance after 2 billing attempts.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep one copy in your chart and will give you one copy for your own records.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all cost of dental treatment. I grant the right to the dentist to release my dental history and other information about my dental treatment to third party payers.

Patient: _____ 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
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 October 16, 2002, 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 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 in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information in connection with our 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 remove 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, friend or other person to the extent necessary to help with your healthcare payment, 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.

Required by Law: We may not use or disclose your health information for marketing communications without your written authorization.

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.

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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 \$3, for each page, \$1 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 April 14, 2003. 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 request.

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 Note: 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: Dr. Angelina Yap
Telephone: 281-647-7873

Patient's Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

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