

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

male female single married other

Social Security _____ Birth Date ____/____/____

Phone (Home): _____ (Work) _____ Ext: _____ (Cell) _____

email address: _____

Mailing Address: _____
Street Apartment #
City State Zip Code

Health History

Have you ever had any of the following? Please check those that apply:

- Heart Attack _____
- Heart Murmur
- Mitral Valve Prolapse
- Heart Surgery _____
- Artificial Heart Valve
- Pacemaker
- Artificial Joints
 - Knee/Hip
 - Other _____
- Diabetes
- Kidney Disease
- Kidney Transplant
- Immunosuppressant Drugs
- Immune Deficiencies
- HIV/AIDS
- Rheumatism/Arthritis
- High Blood Pressure
- Stroke
- Glaucoma
- Tuberculosis

- Cancer _____
 - Radiation Treatment
 - Chemotherapy
 - Surgery _____
- Benign Growths _____
- Excessive Bleeding
- Hemophilia
- Liver Disease
- Hepatitis
 - Hep A/B
 - Hep C
- Jaundice
- Anemia
- Hyperthyroid
- Low Thyroid
- COPD
- Emphysema
- Asthma
- Sinus Problems
- Seasonal Allergies
- Seizures/Epilepsy

- Depression
- Anxiety
- Mental Disorders
 - ADD / ADHD
 - Other _____
- Stomach Problems
 - GERD
 - Other _____
- Ulcers
- Intestinal Disorders
- Alzheimer's
- Parkinson's
- Venereal Disease
- Fainting
- Pregnancy -currently
DUE DATE _____
- Hospitalized

- Bisphosphonate class
Of medications
- OTHER MEDICAL
CONDITIONS: _____

DRUG ALLERGIES

- Penicillin Allergy
- Clindamycin Allergy
- Erythromycin Allergy
- Tetracycline Allergy
- Codeine Allergy
- Hydrocodone Allergy
- Aspirin Allergy
- Ibuprofen Allergy
- Anesthetic Allergy
Type _____

OTHER ALLERGIES

- Latex
- Adhesives
- Acrylics
- Metals
- Black Rubber
- Food Allergies
- Other

Please list the medications you take:

Your Weight _____ lbs

Your Height _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Signature of doctor reviewing medical history Date: _____

Financial Policy

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

PAYMENT MAY BE IN THE FORM OF CHECK, CASH, CREDIT CARD, OR EXPECTED INSURANCE BENEFITS

For Patients using dental insurance benefits to pay for treatment:

As a courtesy, we will file your insurance for you and allow 30 days for insurance payment on your account. On the day of service we will collect only a portion of the fee charged for the services rendered. Any balance left on the account after insurance payment is received is the responsibility of the patient or financial guarantor.

After 30 days, you will receive a statement for the balance on your account –it may show over 30 days past due because we were waiting on insurance payment. To keep your account in good standing please remit payment by the due date on the statement.

A missed appointment or late cancellation fee of \$25 will be assessed for less than 24hrs notice. This fee can be waived 1 time for emergencies only and by request.

By signing below I state that I have read, understood and agree to the above financial policy.

I also understand that I or my guarantor will be ultimately financially responsible for any balances on my account.

Signed: _____ Date ____/____/____

Insurance Information Responsible Party/Guarantor Information

Name of Insured Guarantor: _____
Last First MI (preferred)

Male Female Married Single Other _____

Patient's relationship to insured: Self Spouse Child Other _____

Social Security #: _____ Birth Date: ____/____/____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell#): _____

Email address _____

Address: _____
Street Apartment #
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code Phone

Insurance Plan Name _____

Insurance Address: _____
Street City State Zip Code Phone

Insurance Telephone # (_____) _____

Group ID# _____ Member ID# _____

Photographic Release

In our office we like to photograph our patients for aid in determining their problems and to help come up with the perfect treatment options for them. With these photographs, we can recreate your smile on the computer so that you can see the final results and approve of them before we start any procedure.

Dr. Lowery also uses the photographs with the patient's permission to teach dentists from all over the world how we create beautiful smiles for our patients. She is a member in good standing with the AACD, the American Academy of Cosmetic Dentistry. She also plans to use the photographs to give lectures through out the country on the latest advances of dental technology.

We are very proud of the work we have done and only use our own patients in our marketing and advertising. All of the portraits in our office, on our web site, www.averyranchdental.com , and in our ads are our own patients and photography.

Authorization and Release

I _____, hereby authorize Dr. Elizabeth Lowery and her staff to take photographs, slides, and / or videos of my face, jaws, and teeth. I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature: _____

Date: _____

Who may we thank for referring you? _____

- Avery Ranch Sign
- Insurance Web page
- Avery Ranch Website
- Neighborhood Newsletter
- Newspaper
- Yellow Pages
- Other: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE THE INFORMTATION HANDED TO YOU CAREFULLY.

By signing below I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES

Signed _____ Date ____/____/____

Printed name _____

Avery Ranch Dental

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically on paper, or orally, are kept confidential. This Act gives you the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include tooth restoration services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessments and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent, or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we decide in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information. Including those related to disclosures to family members, other relatives, close personal friends, or any

other person identified by you. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. If you request copies, we will charge you \$30.00 for each set of X-Rays and \$15.00 for staff time to locate and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of 04/14/03 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written Copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA Or to file a complaint:

Privacy Officer

Kelli Welch
14900 Avery Ranch Blvd.
Suite C100
Austin, TX 78717
(512) 246-7645

The U.S. Department of Health & Human
Services
Office of Civil Rights.
200 Independence Avenue. S.W.
Washington, D.C. 20201
(202)619-0257
Toll Free: 1-877-696-6775