

### Patient Information

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street Apartment #

City State Zip Code  
**SS#** - - **DOB** **DL#** **State**

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Ext: \_\_\_\_\_

Cell# \_\_\_\_\_ Email Address \_\_\_\_\_

Married  Single  Child  Other Male  Female

**Emergency Contact**(other than spouse) **Name** \_\_\_\_\_ **Phone#**( \_\_\_\_\_ )

**Address** \_\_\_\_\_ **Relationship** \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

**Location Preferred** 281/ Babcock/ New Braunfels/ Hwy 87/ Southcross/ No Preference

Are you available for short notice appointments? Y/N **Preferred Doctor** \_\_\_\_\_

### Responsible Party Information

( If same as Patient Info leave blank )

Name: \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Male/Female

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code  
**SS#** **DOB** **DL#** **State**

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Ext. \_\_\_\_\_ Best time to call: \_\_\_\_\_

### Employment Information

Employer Name \_\_\_\_\_ Phone# \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Insurance Information

**Primary**  
Name of Insured \_\_\_\_\_ Are you the insured?  Yes  No  
Last First MI

Insurance Plan Name and Address: \_\_\_\_\_

**Insurance Phone #** \_\_\_\_\_ **Employer Name** \_\_\_\_\_

**Insured's DOB** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_

Relationship to patient:  Self  Spouse  Parent  Other \_\_\_\_\_

**Secondary**  
Name of Insured \_\_\_\_\_ SS# \_\_\_\_\_  
Last First MI

Insurance Plan Name and Address: \_\_\_\_\_

**Insurance Phone #** \_\_\_\_\_ **Employer Name** \_\_\_\_\_

**Insured's DOB** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_

Relationship to patient:  Self  Spouse  Parent  Other\_\_\_\_\_

# Smile Assessment Form

Please consider each statement carefully and circle YES or NO. Dr. Hamilton and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or smile.  
YES NO
2. In social situations, I am embarrassed by my teeth or my smile.  
YES NO
3. There are some things about my upper front teeth that I would like to change.  
YES NO
4. There are some things about my lower front teeth that I would like to change.  
YES NO
5. My smile is very important in my job as I deal with the general public.  
YES NO
6. I am concerned about the whiteness/lack of whiteness of one or more of my teeth.  
YES NO
7. I am concerned about the position or angle of one or more of my teeth.  
YES NO
8. I am concerned about the shape of one or more of my teeth.  
YES NO
9. I am interested in learning more about cosmetic dentistry.  
YES NO
10. I am missing one or more of my teeth  
YES NO
11. I would like to know more about implant dentistry.  
YES NO
12. Does your spouse like your smile?  
YES NO

**If I could change one thing about my smile I would** \_\_\_\_\_

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Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.

Name: \_\_\_\_\_ HM#: \_\_\_\_\_ WK #: \_\_\_\_\_ CELL #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**HAVE YOU EVER HAD:**

- Hepatitis
- Liver Disease
- Epilepsy
- Seizures
- Rheumatic Fever
- Kidney Disease
- Diabetes
- Tuberculosis
- Heart Trouble
- Damage Heart Valves
- Artificial Heart Valves
- Congenital Heart Lesions
- Coronary Insufficiency
- Coronary Occlusion
- Arteriosclerosis
- Stroke
- Cardiac Pacemaker
- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- Shortness of Breath
- Chest Pains
- Medical Treatment by X-Ray
- Venereal Disease
- Surgery
- Glaucoma
- Prostate Trouble
- Contact Lenses
- Drug Reaction
- Psychiatric Treatment
- Burning Tongue
- Ulcer
- Sinus Problems
- Asthma
- Treatment for Tumor/Growth
- Prosthetic Replacement (Hip, Knee, etc.)
- HIV Positive

**An Unfavorable Reaction to a Drug Such As:**

- Aspirin
- Barbiturates
- Anesthetics
- Penicillin
- Sulfa Drugs
- Codeine
- Other

**Has A Member of your family:**

Had Diabetes?

Who? \_\_\_\_\_

At What Age? \_\_\_\_\_

**IF FEMALE ARE YOU NOW:**

Pregnant

Due Date \_\_\_\_\_

Taking anti-pregnancy drug

Presently in the Menopause

Past Menopause

**ARE YOU:**

Presently under the care of a physician

Taking any medication now

List of Current Medications

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**HAVE YOU:**

- Ever been told you had gum trouble
- Ever had trench mouth
- Ever been treated for Periodontal Disease (Phorrhea)
- Ever had Orthodontic Treatment
- Had shifting of any teeth

**DO YOU:**

- Ever have sore or popping joints
- Ever have sore teeth
- Ever notice your ankles swell
- Have prolonged bleeding after injury or tooth extraction
- Have a persistent cough or cough up blood
- Get short of breath when you lie down or require extra pillows when you sleep
- Have any blood disorder
- SMOKE

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**Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# Acknowledgement of Receipt of Notice of Privacy Policies

I, \_\_\_\_\_, have received a copy of  
White Pearl Medical Spa's Notice of Privacy Policies.

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## OFFICE USE ONLY

On \_\_\_\_\_, an *Acknowledgment of Receipt of Notice of Privacy Policies* form was delivered. The form was not signed due to:

- Communication barriers which prevent acknowledgement
- An emergency which prevent acknowledgement
- A refusal to sign
- Other \_\_\_\_\_

# KENT M. HAMILTON, D.D.S.INC.

## Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Dr. Hamilton.

*Dr. Hamilton's Legal Responsibilities:* As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced and becomes effective April 14, 2003.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications. This notice will be available upon request.

Copies of this notice are available at your request. For your convenience information regarding how you can contact us is at the bottom of this notice.

**PROTECTED HEALTH INFORMATION USE AND DISCLOSURE:** Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Examples cited below further explain the use and disclosure process.

**Treatment:** Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

**Payment:** Your protected health information may be used and disclosed to obtain payment for services we provided to you.

**Healthcare Processes:** We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

**Person Involved in Care:** In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices 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 protected health information.

**Marketing Health-Related Services:** The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

**Required by Law:** Your protected health information may be used or disclosed if required by law.

**Abuse or Neglect:** As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

**National Security:** Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities

may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

**Appointment Reminders:** Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

## PATIENT RIGHTS

**Access:** At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you \$10.00 for each page and \$75.00 per hour for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option, which is different, we will charge a cost based fee for that format. An explanation of fees can be made available.

**Disclosure Accounting:** Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

**Restrictions:** You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

**Alternative Communication:** Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

**Amendment:** You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

**Electronic Notice:** If you receive a notice electronically, you are entitled to receive the notice in writing as well.

## QUESTIONS AND COMPLAINTS

More information is available to you regarding our privacy policies, please contact us.

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a 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 Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.

Contact Office: \_\_\_\_\_

Telephone: (210) 496-5603 \_\_\_\_\_

Fax: (210) 496-1286 \_\_\_\_\_

Address: 14500 San Pedro' STE 200 \_\_\_\_\_

City, State, Zip: San Antonio, TX 78232 \_\_\_\_\_