

James L. Burk, D.D.S.

15307 FM 1825

Pflugerville, TX 78660

512-989-0888

Patient Information

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

E-Mail: _____ Gender _____ Marital Status: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

City State Zip Code

Health Information

DO YOU HAVE ANY OF THE FOLLOWING DISEASES, ALLERGIES OR HEALTH CONCERNS?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma/Shortness of Breath | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Head injuries | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Halcion <input type="checkbox"/> Valium |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | Due date: _____ | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hearing Loss/Hearing Aid | For the following check only
the items to which you are
allergic. | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> High/low Blood Pressure | <input type="checkbox"/> Glaucoma | | <input type="checkbox"/> Antibiotics: _____ |
| <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> ScarletFever/RheumaticFever | | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Penicillin <input type="checkbox"/> Amoxicillin | |
| <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tetracycline | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Candida | <input type="checkbox"/> Aspirin | |
| <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Acetaminophen/Ibuprofen | |
| <input type="checkbox"/> Inflammatory Rheumatism | <input type="checkbox"/> Herpes | | |

- Do you have a hip, knee or other joint replacement? Yes No
- Have you ever been diagnosed with a heart murmur? Yes No
- Have you ever been diagnosed with mitral valve prolapse? Yes No
- Have you ever been diagnosed with rheumatic fever or rheumatic heart disease? Yes No
- Are you blood donor eligible? Yes No

• Do you have a history of addiction? Yes No
If yes, please explain: _____

• Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____

• Have you ever required a blood transfusion? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

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 doctor at the next appointment without fail.

Signature of patient, parent or guardian Date: _____

Referral Information

Whom may we thank for referring you to our practice? _____

Responsible Party Information

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Phone (Home): _____ (Work): _____ Ext: _____ (Mobile): _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Patient Employment Information

Employer Name: _____ Occupation: _____
Address: _____
Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Subscriber of Insurance Policy _____
Subscriber's Birth Date: _____ Last _____ First _____ MI _____ SS#: _____
Subscriber's Address: _____
Street _____ City _____ State _____ Zip Code _____
Subscriber's Employer Name: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name and Address: _____
Group or certificate # of Plan _____

We are committed to keeping our fees congruent with the quality of dentistry that we deliver. Therefore, we will assist you in maximizing your dental benefits as appropriate for your choice of treatment. Deductible and co-payment is to be made at the time of treatment and with completed insurance information, your dental claim will be filed electronically on the date of service.

Patient Consent

I understand the above information is necessary to provide with dental care in a safe and efficient manner I have answered all questions truthfully and to the best of my knowledge. I also authorize diagnostic aids to be taken as deemed appropriate by my doctor such as x-rays, study models, photographs, etc, in order to make a thorough diagnosis of my dental needs. I also authorize my doctor to perform all recommended treatment mutually agreed upon by means to use the appropriate medication and therapy agents indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that my doctor choose and employ such assistance as deemed fit to provide recommended treatment. I also understand that all responsibility for payment for dental services provided in this office for myself or other patients I am financially responsible for, is due and payable at the time of service unless financial arrangements have been made with this office. In the event payments are not received by agreed upon dates, I understand that a 1 ½% finance charge (18% APR) may be added to my account. I consent to insurance benefits being assigned to this office when appropriate.

I agree to provide this office a 24 hour notice of a change or cancellation of my appointment to avoid a charge.

Patient Signature _____ Guardian if patient under 18 _____ Date: _____

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT: _____ Relationship: _____

Phone Numbers: _____

James L. Burk, D.D.S.

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 4/15/03, 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 the 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 for 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 information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or 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 revoke 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 member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, 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 judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement 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.

Marketing Health-Related Services: We will not use health information for marketing communications without your written authorization.

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

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 of the health or safety of others.

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 institutions or law enforcement officials 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 voice-mail 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 \$0.____ for each page, \$____ 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 requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We ar□

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 Notice: 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 violate 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.

James L. Burk D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT –PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Noticed of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Pamela

Telephone: (512) 989-0888 Fax: (512) 989-2728

Address: James L. Burk • 15307 FM 1825, Suite 4 • Pflugerville, TX 78660

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include a completed Consent in the patient's chart.**