

TOWNE LAKE DENTISTRY

Patient Information:

Last Name:	First Name:	Middle Initial:
How do you wish to be addressed?	How did you hear about us? ◯ Insurance ◯ Online ◯ Flyer/Event ◯ Family/Friend:_____ ◯ Other:_____	
Social Security Number:	Date of birth:	Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed
Email Address:	Cell Phone:	Biological Sex: ◯ Male ◯ Female
Home Address:	City: / State: / Zip Code:	
Address Line 2:	Home Phone:	

Employer Information:

Employer:	Occupation:		
Work Address:	Work City:	Work State:	Work Zip Code::
Work Address Line 2:	Work Phone:		

Emergency Contact:

Emergency Contact:	Relation:	Phone:

Guarantor or Responsible Party:

First and Last Name:	Relationship to Patient: First and Last Name:		
Address, if different from patient address above:	City:	State:	Zip Code:
Social Security Number of Responsible Party:	Home Phone:		

Primary Dental Insurance Information:

Name of Insurance Company:	Phone Number:		
Address:	City:	State:	Zip Code::
Policy Number:	Group Number:		

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Medical History

☐ Yes	☐ No	Are you under a physician's care? If yes:	**For Staff Use Only**
		Physicians Name: _____	Unless otherwise indicated below, add any "Yes" to the patient's "Problems" in Medical Window.
		Telephone: _____	
☐ Yes	☐ No	Are you currently taking any medications or substances? If yes, please list below. Examples: St. Johns Wart, Valarium, Ambien, etc.	
			Put all medications in Medications.
☐ Yes	☐ No	Are you allergic to any medications or substances, e.g. penicillin, amoxicillin?	Select in Allergies & type in Med Urgent
☐ Yes	☐ No	Are you sensitive or allergic to latex?	Also type in Med Urgent, **Blue Gloves**
☐ Yes	☐ No	Are you pregnant or suspect you might be?	
☐ Yes	☐ No	Do you use birth control medications?	
☐ Yes	☐ No	Do you have an artificial heart valve, prior history of infective endocarditis, congenital heart disease or heart transplant with complications?	Add to "Problems" and check box "Premedicate" in Medical Window
☐ Yes	☐ No	Do you have a pacemaker?	
☐ Yes	☐ No	Do you have high blood pressure?	
☐ Yes	☐ No	Have you every been diagnosed with Hepatitis?	
☐ Yes	☐ No	Have you ever had a major surgery or been hospitalized for any reason?	
☐ Yes	☐ No	Have you ever had radiation therapy in the head, neck and/or shoulders area?	Add to "Problems" and type "No Extractions" in Med Urgent
☐ Yes	☐ No	Do you have artificial joints or prosthesis? **If yes, please contact your doctor to discuss whether antibiotics are advised in connection with your dental visit today and, if so, to obtain those antibiotics.**	Add to "Problems" and check box "Premedicate" in Medical Window
☐ Yes	☐ No	Do you bleed excessively after being cut or injured?	
☐ Yes	☐ No	Are you diabetic?	
☐ Yes	☐ No	Do you smoke, chew or otherwise use any form of tobacco?	
☐ Yes	☐ No	Have you tested positive for HIV or been diagnosed with AIDS?	Add to "Problems" and type "No Benzo" in Med Urgent
☐ Yes	☐ No	Do you have acute narrow angle or untreated open angle glaucoma?	Add to "Problems" and type "No Benzo" in Med Urgent
		NOTE: Benzodiazepenes can cause complications when mixed with certain medicines routinely prescribed for the previous two conditions.	
☐ Yes	☐ No	Do you have any disease, condition, or problem not listed here? Please explain.	

I understand that an accurate and complete medical history is necessary for my dentist and dental office staff to be able to diagnose and perform dental services properly (including prescribing appropriate medications) and that serious consequences can arise if the above information is not accurate and complete. I understand that it is my responsibility to notify the office of any changes in a timely manner and before further treatment. I certify that the foregoing information and any updated information I provide is/will be accurate and complete at the time given. Further, on behalf of myself, my heirs and/or assigns, I hereby release and hold Towne Lake Dentistry and its affiliates, and their owners, employees, agents, and contractors (including dentists), harmless from any and all claims, judgments, damages, liabilities, losses, costs and expenses, including attorneys' fees and disbursements, arising from or relating to any errors, omissions or misstatements (whether knowing or

Signature or Guardian's Signature:_____ Date:_____

Patient Printed Name:_____

Doctor Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF Towne Lake Dentistry

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. If you have any questions about this notice, please contact

Towne Lake Dentistry
9740 Barker Cypress #113
832.220.4300

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, contractors, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- ***For Treatment***

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care out- side this office and may require information about you that we have.

- ***For Payment***

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan in- formation about a service you received here so your health plan will pay us or reimburse you for the service.

- ***For Health Care Operations***

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

- ***Appointment Reminders***

We may contact you as a reminder that you have an appointment for treatment or medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.

- ***Health-Related Products and Services***

We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to receive communications about treatment alternatives or health-related products and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- ***To Avert a Serious Threat to Health or Safety***

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- ***Required By Law***

We will disclose health information about you when required to do so by federal, state or local law.

- ***Organ and Tissue Donation***

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- ***Military, Veterans, National Security and Intelligence***

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- ***Workers' Compensation***

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- ***Public Health Risks***

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- ***Health Oversight Activities***

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- ***Lawsuits and Disputes***

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- ***Law Enforcement***

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena,

warrant, summons or similar process, subject to all applicable legal requirements.

- ***Coroners, Medical Examiners and Funeral Directors***

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- ***Information Not Personally Identifiable***

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- ***Family and Friends***

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse or friend when you bring your spouse or friend with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- ***Right to Inspect and Copy***

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

- ***Right to Amend***

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

- ***Right to an Accounting of Disclosures***

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations.

It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). 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.

- ***Right to Request Restrictions***

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

- ***We are Not Required to Agree to Your Request***

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications.

- ***Right to Request Confidential Communications***

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For ex- ample, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to:

Towne Lake Dentistry
9740 Barker Cypress #113
832.220.4300

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- ***Right to a Paper Copy of This Notice***

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact

Towne Lake Dentistry
9740 Barker Cypress #113
832.220.4300

TOWNE LAKE DENTISTRY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment *

Patient Name:_____ DOB:_____

I, the patient identified above, acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature:_____ Date:_____

For Office Use Only

If applicable - We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgment
☐ An emergency situation prevented us from obtaining the acknowledgment
☐ Other (Please Specify):

_____

_____

CHILDREN/DEPENDENTS

If applicable, I am signing the above Acknowledgement of Receipt of Privacy Practices, as well as the TLD Office Policy and Appointment Policy, on behalf of myself, as well as my children and/or other legal dependents who are patients of Towne Lake Dentistry, as listed below:

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Signature of Parent/Guardian:_____

Date:_____

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Towne Lake Dentistry Financial Policy & Appointment Policy

Your understanding of our financial responsibility policy and appointment policy is an essential element of our office being able to provide the best possible dental care and service to you and your family. Some policies may have changed since your last visit. Please read and initial EACH item and sign below:

Insurance

_____ You are ultimately responsible for knowing what your plan does and does not cover, and knowing any administrative rules that apply (e.g. in-network/out of network; out of pocket balance; copayment; 6-12-24 month waiting periods; deductible; etc.). You are also responsible for confirming whether we accept your insurance plan before each visit, understanding that our contracts with various insurance providers may change year-to-year or throughout the year.

_____ Each patient is encouraged to verify if specific procedures are covered or not covered (e.g. missing tooth clause, downgrades to cheaper procedures, etc.) and the percentage of each procedure that is covered.

_____ As a courtesy, we will attempt to verify your eligibility and benefits. However, we cannot guarantee that the information received is accurate due to insurance policy changes and real-time/up-to-date system information. We will bill your insurance company with whom we have a contract agreement. Once your benefits have been determined, payments of any copays, coinsurance, deductible and fees are required at the time services are rendered.

_____ Once your insurance company has processed a claim, any balance as determined by your insurance plan to be "patient's responsibility" and/or "non-covered service" will be your responsibility. If you disagree with the "patient responsibility" amounts due to our office per your insurance's Explanation of Benefits (EOB), please immediately call your insurance company for further explanation.

_____ Failure to inform and provide us with your current or new insurance information and/or to reply back to any requests for additional information may result in the entire bill being your responsibility.

General

_____ Outstanding balances are due unless payment arrangements have been made in advance with our office.

_____ Independent specialists to whom we may refer you (e.g. Oral Surgeon, Periodontist, Pediatric Dentist, Orthodontist, etc.) will also bill independently. If you receive a bill from them, you will need to contact their office for further detail.

_____ Our office DOES NOT bill third parties (e.g. automobile insurance, worker's comp). If you are entitled to any such third-party benefits, your visit will be considered self-pay, and you will be given a receipt that you may file with the third party. Our office does not accept workman's compensation cases.

_____ We accept all major credit cards, checks, cash, Care Credit, and some in-house financing.

Fees

_____ There is a $50 filing fee for predetermination of benefits. You acknowledge, however, that even a predetermination of benefits is only an estimate and may not accurately reflect your insurance benefits as determined by your insurance provider after treatment.

_____ We reserve the right to charge for forms to be filled out and/or typed letters requiring a signature from our doctors or dental staff. We also reserve the right to charge for transferring records to another dental office.

_____ There will be a $25 charge for all returned checks due to insufficient funds.

_____ If a refund is due to you, we will advise you to pick up the check when available. We will send the check to you by mail if asked. If you request the refund to be mailed and the check is lost in the mail, there will be a $25 stop payment charge to cancel the missing/lost check.

Appointments

_____ If you are more than 15 minutes late for your appointment, we will do the best we can to accommodate you without compromising your dental care, but you may be asked to reschedule.

_____ Please notify our office in advance if you cannot keep your appointment. We reserve the right to ask you to seek care from another dentist, if you miss three appointments without notification or cancel three appointments without 24 hr notice.

Signature:_____ Date:_____

If you no show for your scheduled hygiene appointment or cancel less than 24 hours in advance, there will be a $50 charge. If you no show for your scheduled operative appointment with the doctor or cancel less than 24 hours in advance, there will be a $150 charge.

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TOWNE LAKE
DENTISTRY

Dental Questionnaire

Do you have any dental concerns?

☐ Bleeding gums ☐ Food getting stuck between teeth ☐ Bad breath
☐ Sores or growths in mouth ☐ Discoloration of teeth ☐ Alignment of teeth ☐ Other

_____

Are you experiencing any dental- related pain? Please describe the pain and location.

☐ Swelling ☐ Sensitive to cold ☐ Sensitive to hot ☐ Trouble chewing/ biting
☐ Pressure ☐ Bleeding ☐ Jaw pain

_____

How long have you had this problem? _____

Does anything make this problem better? List all remedies, including medications taken.

_____

When was your last dental appointment? _____

Was a dental cleaning performed? ☐ Yes ☐ No

Have you had any dental work done within the last year? If yes, please list procedure(s).

_____

Do you clench or grind your teeth? ☐ Yes ☐ No ☐ Daytime ☐ Nighttime

Does your jaw click or pop when opening or closing your mouth? ☐ Yes ☐ No

Do you snore at night? ☐ Yes ☐ No

Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep? ☐ Yes ☐ No

Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)? ☐ Yes ☐ No