PATIENT INFORMATION

Daniel Antee, DDS
Megan Tanner, DDS

102 Christie Street, Lufkin, Texas 75904
936-634-6110

Date: ______________________

Patient Information

❑Mr. ❑Mrs. ❑Miss ❑Ms.

LEGAL NAME:

Last: ________________________________

First: ___________________ MI: _________

Peferred Name: ________________________

Address: _____________________________

City: ____________ State: ______ Zip: ______

Home Phone: __________________________

Mobile Phone: _________________________

Email: _______________________________

Employer: ____________________________

Work Phone: __________________________

Sex (Circle): M or F Drivers Lic #: ___________

SSN: _________________ DOB: ___________

Marital Status (Circle): Single Mar Div Sep Wid

In Case of Emergency

Person to contact in case of emergency:

Name: ____________________________

Relationship: ________________________

Phone Number: ______________________

Insurance Information

Primary Ins: ___________________________

Policy Holder: __________________________

ID #: ________________ Group #: _________

Policy Holder DOB: ______________________

Patient's Relationship to Policy Holder (Circle)

Self Spouse Child Other

Employer: _____________________________

Parent/ Guardian (if applicable): _____________

Address: ______________________________

City: ___________ State: ______ Zip: ______

Referral Source

Who may we thank for referring you? (Circle)

Doctor Family Friend Flyer Internet Ad Other

Name: ________________________________

How may we contact you?

Please circle one on each of the following:

Preferred contact method: Home # Mobile # Email

Preferred confirmation/recall method: Home # Mobile # Email

The above information is true to the best of my knowledge. I authorize insurance benefits be paid directly to the dentist. I understand I am financially responsible for any balance. I authorize The Dental Center of Lufkin or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ______________________________________ Date: __________________

PATIENT HEALTH & DENTAL INFORMATION

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Medical History

Name: ________________________________ Date: _____________

Do you have any of the following: (Please Check)

❑ Aids/HIV Positive	❑ Alzheimer's Disease	❑ Artificial Heart Valve	❑ Artificial Joint
❑ Asthma	❑ Cancer	❑ Chemotherapy	❑ Chest Pains/Angina
❑ Cold Sores/Fever Blisters	❑ Diabetes	❑ Drug Addiction	❑ Emphysema
❑ Epilepsy or Seizures	❑ Excessive Bleeding	❑ Fainting Spells/Dizziness	❑ Glaucoma
❑ Heart Attack/Failure	❑ Heart Disease	❑ Heart Murmur	❑ Heart Pacemaker
❑ Hepatitis A	❑ Hepatitis B	❑ Hepatitis C	❑ High Blood Pressure
❑ High Cholesterol	❑ Hypoglycemia	❑ Kidney Problems	❑ Leukemia
❑ Liver Disease	❑ Low Blood Pressure	❑ Mitral Valve Prolapse	❑ Osteoporosis
❑ Psychiatric Care	❑ Radiation Treatments	❑ Renal Dialysis	❑ Sinus Trouble
❑ Stroke	❑ Tuberculosis	❑ Thyroid Disease	❑ Ulcers
			❑ Other: _______________

Are you presently under the care of a physician? (Please Circle): Y or N If yes, What for? ________________________________

Have you ever been hospitalized or had a major operation? (Please Circle): Y or N If yes, for what? _______________________

Have you ever had a serious head or neck injury? (Please Circle): Y or N If yes, please list: ________________________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? (Please Circle): Y or N
If yes, which one and what for? __________________________

Do you use tobacco? (Please Circle): Y or N

Do you use controlled substances? (Please Circle): Y or N

Women are you……. ❑Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Latex ❑ Metal ❑ Sulfa Drugs
❑ Local Anesthetics ❑ Other: ____

Are you currently taking any medications: Y or N If yes, please list: ____
____

Dental History

Date of your last dental treatment or cleaning: _________________. Do you have panoramic x-ray or full mouth x-rays that are less than 5 years old? _________________. Do you have bitewing x-rays that are less than 1 year old? __________________________.

Do you have a history of? (Please Check)

❑ Gum Disease	❑ Halitosis (bad breath)	❑ Grinding Teeth
❑ Abscesses	❑ Teeth Sensitivities	❑ Clicking or Popping TMJ
❑ Sores (ulcers)	❑ Cold Sores/Fever Blisters	❑ Pain in Jaw or Joint

Are you currently happy with the appearance of your teeth? __________________
Are there any other dental conditions or experiences of which we should be made aware of? ______________________________

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Consent for Services

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. I grant permission to you or your assignee to contact me to discuss matters related to this form. I grant my permission for any and all photographs, intra oral photos or x-rays to be used for educational purposes as well as my own diagnosis if necessary.

Appointment Policy

In this very busy world, we make every effort to schedule your appointment to fit your personal schedule. We do not overbook as do so many medical and dental practices. Your appointment is yours exclusively, should you cancel your appointment with less than 48 hours' notice or fail to be here at your appointed time, our dental chair is empty, time is wasted. You have delayed treatment for another patient. Overhead expenses continue and the cost of dentistry ultimately rises. We are committed to improving your oral health. You on the other hand must be committed to making your scheduled appointments in order to receive the necessary dental treatment. **We ask that you provide us with no less than 24 hours' notice should you need to cancel or reschedule your appointment for any reason.**

Acknowledgement of Receipt of Notice of Privacy Policy

I, ____, have received a copy of The Dental Center of Lufkin's Notice of Privacy Practices.

Assignment of Benefits Agreement

Our office will accept an assignment of benefits from your insurance company with provisions listed below. The following provisions identify our policies governing insurance claims:

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our office from your insurance company. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide the service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any confusions or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company however; it is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.
- Returned checks are subject to a $25.00 admin fee and all balances older than 6 days will be subject to collection action and fees.
  I HAVE READ AND ACCEPT TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Patient Signature: ____ Date: _______________________________

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NOTICE OF PRIVACY PRACTICES

HIPAA 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 Information Portability and 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 properly 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.
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 cleaning services. Another would be contacting your physician or pharmacist about your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment for your treatment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment 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 references to individually identifiable information. 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 our 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. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests 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. Your medical records remain our property. We may charge a reasonable fee for copying your records for you.
- 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 your protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of The Notice of Privacy Practices currently in effect. We have the right to change the terms of our Notice of Privacy Practices and to make the new 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 written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

You may contact the government about HIPAA at
U.S. Dept. Of Health & Human Services
Office of Civil Rights
200 Independence Av., S.W. Washington, DC 20201
877-696-6775