Keller Town Dental
New Patient Medical History

Patient Name:_____ Preferred Name (if different):_____
Gender: Male or Female Married: Yes or No DOB: _____Social Security#:_____
Patient Address: _____ City, State, Zip:_____
Home # ( ) _____-_____ Cell # ( ) _____-_____ Work # ( ) _____-_____
Email Address: _____
Emergency Contact Name **and** Phone Number: _____Relation:_____
Physician: Name & Phone Number:_____
Pharmacy: Name & Phone Number:_____
Are you in the care of an orthodontist? Yes or No // When & Where? _____
How did you hear about our office? _____
Have you been seen in any other dental office? Yes or No When & Where? _____

Please Mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes/ No			Yes/ No	
Cardiovascular Disease	___	___	Bulimia	___	___
Angina	___	___	Malnutrition	___	___
Arteriosclerosis	___	___	Gastrointestinal disease	___	___
Congestive Heart Failure	___	___	G.E. Reflux	___	___
Damaged Heart Valves	___	___	GERD	___	___
Heart Attack	___	___	Persistent Heartburn	___	___
Heart Murmur	___	___	Ulcers	___	___
Low Blood Pressure	___	___	Thyroid Disease	___	___
High Blood Pressure	___	___	Stroke	___	___
Other Congenital Heart Defects	___	___	Glaucoma	___	___
Mitral Valve Prolapse	___	___	Hepatitis, Type ____	___	___
Pacemaker	___	___	Jaundice, or Liver Disease	___	___
Rheumatic Fever	___	___	Epilepsy	___	___
Rheumatic Heart Disease	___	___	Fainting Spells	___	___
Abnormal Bleeding	___	___	Seizures	___	___
Anemia	___	___	Tourette's Syndrome	___	___
Blood Transfusion	___	___	Neurological Disorders, Specify	___	___
Hemophilia	___	___	Sleep Disorder	___	___
AIDS or HIV Infection	___	___	Do You Snore?	___	___
Arthritis	___	___	Mental Health Disorders, Specify	___	___
Autoimmune Disease	___	___	Recurrent Infections, Specify	___	___
Rheumatoid Arthritis	___	___	Kidney Problems	___	___
Systemic Lupus Erythematosus	___	___	Dialysis	___	___
Asthma	___	___	Night Sweats	___	___
Bronchitis	___	___	Osteoporosis	___	___
Emphysema	___	___	Persistent Swollen Glands in Neck	___	___
Sinus Trouble	___	___	Severe Headaches/Migraines	___	___
Tuberculosis	___	___	Severe or Rapid Weight Loss	___	___
Cancer	___	___	Sexually Transmitted Disease	___	___
Chemotherapy/Radiation	___	___	Excessive Urination	___	___
Chest Pain Upon Exertion	___	___	High Cholesterol	___	___
Chronic Pain	___	___	Dementia/Alzheimer's	___	___
Diabetes Type I or II	___	___	Autism	___	___
Anorexia	___	___			

Patient/ Legal guardian signature:_____Date:_____

Are you taking any medications/supplements? Please provide an up to date list.

☐ Not taking any medication

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Joint Replacement: Have you had an orthopedic total joint replacement (hip, knee, elbow, etc.)?
Yes or **No**. If Yes, Date:_____ Any Complications?_____ PreMed recommended?_____

Are you taking or scheduled to begin taking an antiresorptive agent (Fosamax, Actelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease?_____

Have you ever been hospitalized? **YES** or **NO** If yes, please explain why and when. _____

_____

Allergies- Are you allergic to or have you had a reaction to: (please specify what reaction)-

	Yes/No		Yes/No
Local Anesthetics	__ __	Acrylic	__ __
Aspirin	__ __	Iodine	__ __
Penicillin	__ __	Hay fever, Seasonal	__ __
Barbiturates, Sedatives, Sleeping Pills	__ __	Animals	__ __
Sulfa Drugs	__ __	Food	__ __
Codeine or other Narcotics	__ __	Antibiotics? If so which ones _____	
Metals	__ __	Other	
Latex (rubber)	__ __	_____	

Do you use tobacco (circle one: Smoking / snuff / chew?)_____.
If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED

Please mark yes or no if you have or have not had any of the following diseases or problems.

	Yes/No
Artificial (prosthetic heart valve)	__ __
Damaged Valves in Transplanted Heart	__ __
Congenital heart disease	__ __

Have you ever been told you need pre-medication before dental cleanings or dental work? YES __ NO __
If so, what do you take? _____

Woman only, Are you?	Yes/No
Pregnant?	__ __
Number of weeks: _____	
Do you have doctor's clearance for dental work?	__ __
Taking birth control or hormonal replacement?	__ __
Nursing?	__ __

Patient/ Legal guardian signature:_____Date:_____

Print Name:_____

Dental History:

What brought you into our practice? _____

_____

How do you feel about your smile? _____

_____

Anything you would like to change about your smile? _____

_____

Are you interested in invisalign?_____

Are you interested in whitening? _____

_____

Are you interested in veneers / crowns? _____

_____

Is there anything else about your mouth that we should know about?_____

_____

_____

_____

Do you have history of?:

	Yes/No		Yes/No
Dental Implants:	__ __	Grinding:	__ __
Root Canals:	__ __	Clenching:	__ __
History of Jaw Clicking:	__ __	Wearing a Night Guard:	__ __
Jaw Pain:	__ __	Snoring:	__ __
Cracked Teeth:	__ __	Sleep Apnea:	__ __
Dental Fear:	__ __		

_____ _____

Print patient name Date

_____ _____

Signature Doctor's Signature

PRIVACY OFFICER: ALEXIS MEDRANO

EFFECTIVE: MAY 17, 2017

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protect health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this Notice

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How we may use and disclose medical information about you

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services.

Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment maybe collected from you, an insurance company or a third party.

Example: We may need to send you protective health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operation. We may use and disclose medical information about your for health care operations to assure that you receive quality care.

Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Uses or Disclosures That Can Be Made Without Consent or Authorization

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities
- Other covered entities' and providers' treatment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

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.

Uses and Disclosures of Protected health Information requiring your Written Authorization

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will there after no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided for you.

Your individual rights regarding your medical information

COMPLANTS: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request for a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. 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 with emergency treatment. To request restrictions, you must submit your request in writing to the privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Please list name(s) of relatives/caregivers to whom dental information regarding you or your child may be released to in your absence:

Name:_____Relation:_____
Name:_____Relation:_____

Name:_____Relation:_____
Name:_____Relation:_____

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the privacy officer at this practice. 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. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

*Are staff member of Keller Town Dental allowed to leave detail messages regarding finances, treatment, or any correspondence on home number given **YES** or **NO**

*Are staff member of Keller Town Dental allowed to leave detail messages regarding finances, treatment, or any correspondence on cell number given **YES** or **NO**

*Are staff member of Keller Town Dental allowed to leave detail messages regarding finances, treatment, or any correspondence on email given **YES** or **NO**

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this included medical and billing records but does not include psychotherapy notes, information complied for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that maybe used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request the copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or the other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND: If you feel that medical 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 for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to Privacy Officer at this practice. In addition, you must provide a reason that supports your request. 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 the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

RIGHT TO AN ACCOUNTING OF NON-STANDARD DISCLOSURES: You have the right to request a list of disclosures we made of medical information about you. To request this list, you must submit your request to the privacy officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than 6 years, and may not include dates before April 12, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list request with in a 12 mon period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the privacy officer at this practice.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the revised or change Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper corner of the first page.

Patient Name:_____DOB:_____

Patient/Legal guardian signature:_____Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice Privacy Practice Acknowledgment, but was unable to do so as documented below.

Date:_____Initials:_____Reason:_____

Office Policy

Fees:

Payment for services is due at the time services are rendered. Payment options include cash, check, MasterCard, Visa, American Express, Discover, and Care Credit.

As a courtesy to our patients, we file all claims to the insurance company. The patient is expected to pay all charges not covered by insurance company at the date of service.

If the insurance does not pay claim, the patient will be responsible for charges and will be billed. You will have 30 days to address or an interest rate of 7%, per billing cycle, will be charged to your account.

Your dental insurance benefits were verified by our office according to information provided by you. The benefits quoted by your insurance company are not a guarantee of payment or coverage. You will be responsible for any amount not covered.

If accounts are forced to be forwarded to collection agency, there will be a 33.3% interest fee.

_____**Patient initials**

Please be aware that some insurance companies downgrade the price of composite resin fillings to the amalgam rate. As a courtesy, Keller Town Dental does the best to anticipate fillings, and crowns being downgraded.

Missed appointment policy:

When you are scheduled, we do not "double book" and the appointment time is reserved just for you. If an appointment cannot be kept, we kindly ask for a 48 business hours notice. There will be a $50 missed appointment fee. If you are more than 15 minutes late, we consider this a missed appointment.

Returned Check Policy:

$30 fee

X-Ray Duplications:

Original xrays are property of Keller Town Dental. If copies are needed, there is a $15 charge for duplication. X-Rays are sent to Baylor Imaging Center for duplication and is returned in 10 working days from day of payment.

I have read and accept the office policy. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself in the dental practice.

_____ _____

Patient or parent/legal guardian signature Date