Patient Information

Name_____Date_____

Street_____City_____State_____Zip_____

Home Phone _____Alternate Phone_____

Date of Birth_____ SSN _____ Male _____Female_____

Marital Status_____ Spouse's Name_____

E-Mail address_____

Employer_____ Occupation_____

Address_____ Work Number _____EXT_____

City_____State_____Zip_____

Insurance Information

Will you be using dental insurance for your treatment? _____Yes _____No

Referral Information

Referred By_____

Family Dentist_____ How Long_____

Physician_____ Phone Number_____

Dental History

What is your biggest concern about your gums, mouth, or teeth?

Have you had periodontal treatment before? If yes, when and where?

How often and when was your last cleaning?

How would you feel if you had to lose teeth?

What are you currently doing for your oral health care? Check all that apply.
Flossing/how often_____ Brushing/how often (Manual**)** _____ (Electric**)**_____
Water pick_____ Proxabrush_____ Mouthrinse_____ Other_____

Check all that apply to you

( ) Swollen or bleeding gums	( ) Bad breath or mouth odor	( ) Bad tastes
( ) Painful gums or teeth	( ) Sensitivity to hot or cold	( ) Clenching or grinding
( ) Loose teeth	( ) Increasing space between teeth	( ) Unhappy with smile
( ) Snoring/Sleep Apnea	( ) Jaw/Joint pain	( ) Other

Medical History

	Yes	No
1. **Do you have any known allergies? If yes, list**_____	____	____
2. Have you had any serious illness, operation, or hospitalization in the past?.....	____	____
3. Are you presently under the care of a physician?.....	____	____
4. Do you smoke or use tobacco products? How much?_____ How long?_____.....	____	____
5. Do you drink alcoholic beverages more than 3-4 times a week?	____	____

HAVE YOU HAD ANY OF THE FOLLOWING?

	Y	N		Y	N
HIGH BLOOD PRESSURE			DIABETES		
HEART MURMURS			THYROID DISORDERS		
PROLAPSED MITRAL VALVE			BLEEDING PROBLEMS		
RHEUMATIC FEVER			BLOOD DISORDERS		
HEART PROBLEMS			ARTHRITIS		
ANGINA			JOINT IMPLANTS		
HEART ATTACK			NERVOUS DISORDERS		
PACEMAKER			EPILEPSY/SEIZURES		
STROKE			HEADACHES		
TUBERCULOSIS			STEROIDS IN LAST 2 YEARS		
EMPHYSEMA			CANCER		
ASTHMA			RADIATION/CHEMOTHERAPY		
DIALYSIS			COMPLICATION WITH ORAL SURGERY		
KIDNEY DISEASE			OSTEOPOROSIS		
ALCOHOL/CHEMICAL DEPENDENCY			**WOMEN ONLY ARE YOU CURRENTLY:**		
HEPATITIS/LIVER DISEASE			PREGNANT		
HIV+/AIDS			BREAST FEEDING		
			MENSTRUAL PROBLEMS		

9.List **any** drugs or medicines that you are currently taking to include prescription/non-prescription drugs, aspirin, birth control, vitamins, and herbs.

DRUG	DOSAGE/HOW OFTEN?	HOW LONG

PATIENT SIGNATURE_____DATE_____

OFFICE USE ONLY----------

Blood pressure_____/pulse_____

Medical history reviewed\updated on:_____Date_____Doctor

Timothy M. Hale, DDS
Board Certified in Periodontics

INFORMATION FOR OUR PATIENTS WITH DENTAL INSURANCE

Dental insurance is playing a larger role in helping people obtain dental treatment. Since we feel strongly that our patients deserve the best dental care we can provide and in an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

We consider our relationship with you to be of primary importance. We always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As a patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your dental insurance benefits; but to reemphasize; we have no relationship or responsibility to your insurance company.

FACT #1: Dental insurance is not meant to be "PAY-ALL," it is only a partial aid in paying for your dental care.

FACT #2: Many plans tell their insured that they will cover "up to 80%" or "up to 100%." In spite of what you are told, we have found many plans cover only 40% to 50% of the average fee. Some plans pay more…. some pay less. The amount your plan pays is determined by the contribution you and your employer make to your dental plan. The smaller the contribution paid into the plan for "insurance," the less you will receive. It is your responsibility to advise us of your insurance coverage and restrictions.

FACT #3: It has been the experience of many dentists that some insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying "our benefits are low." Remember, you get back what you and your employer put into the insurance coverage less the profits of the insurance company. In dealing with over 1,000 dental insurance plans, most plans do not cover our fees.

FACT #4: Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered and varying fees that the plan will allow. We will do our best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.

FACT #5: Many routine dental services are not covered by insurance carriers. We make our recommendations based on your needs and not on what your insurance may or may not cover.

Please do not hesitate to ask us any questions about our office policy. We want you to be comfortable in dealing with these matters and we urge you to ask us if you have any questions regarding our services and/or fees. We will fill out and file insurance forms at no charge to you for most procedures. We will do all we can to assure you of your maximum benefits.

If you have any questions regarding your insurance, please contact your insurance carrier regarding the specifics and details of the plan they are operating on your behalf.

- ❑ I authorize the release of all necessary information.
- ❑ I authorize payment of benefits directly to the provider.
- ❑ I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.

Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Practice Limited to Periodontics and Implants
810 South Mason, Suite 325, Katy, Texas 77450, (281) 392-6000

American Academy of Periodontology: American Dental Association

Insurance Information

Member's Name_____ Relationship to patient _____

Member's SS#_____D.O.B_____ Day Time Number_____

Insured's Employer_____ Patient's first Visit_____

Patient's Name_____D.O.B_____SS#_____

For Office Use Only

Insurance CO. Name_____Group#_____

Address_____ Phone_____

Deductible $_____- Met _____Y_____N Calendar Year ____Y____N Pre D required _____Y_____N

Payable at %_____ Max $_____Used $_____Remaining_____

Spoke to_____on _____Notes_____

_____

HIPAA PRIVACY FORM 3

Consent for Use and Disclosure of Health Information

USE OF THIS FORM IS OPTIONAL

Purpose: In cases where **Timothy M. Hale D.D.S.** has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

Timothy M. Hale D.D.S. Katy Periodontics Management, Inc.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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 Notice 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: Rene' VanWave _____

Telephone: 281-392-6000 _____ Fax: 281-392-6811 _____

E-mail: Katyperio@consolidated.net _____

Address: 810 S. Mason Rd Ste 325 Katy, TX 77450 _____

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 heath 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 completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Thank you Dr. Timothy M. Hale

{Timothy M. Hale D.D.S Katy Periodontics Management, Inc.}

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 (04-01-03), 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 this 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 to 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 judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment 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 your 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 or 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 institution or law enforcement official 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 voicemail 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.

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 are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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 violated 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.

Contact Officer: Rene' VanWave

Telephone: 281-392-6000 Fax: 281-392-6811

E-mail: katyperio@consolidated.com

Address: 810 South Mason Rd Ste 325 Katy, TX 77450

{Timothy M. Hale D.D.S Katy Periodontics Management, Inc.}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

_____

_____

_____