

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
E-MAIL _____ CELL PHONE _____ HOME PHONE _____
SS#/SIN _____ BIRTHDATE _____
CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____
BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____
INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

ITEM 07-0515767/27000

X

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

REGISTRATION

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LAVITRA IN THE LAST 24 HOURS?.	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			15. DO YOU USE TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____			17. ARE YOU WEARING CONTACT LENSES	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING.	<input type="checkbox"/>	<input type="checkbox"/>	19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY.	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY:		
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	<input type="checkbox"/>	<input type="checkbox"/>
11. HAVE YOU HAD A RECENT WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU NURSING	<input type="checkbox"/>	<input type="checkbox"/>
			ARE YOU TAKING BIRTH CONTROL PILLS	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA)	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>

ITEM 27011

PATIENT'S NUMBER _____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

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

Name (please print)

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgment 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) _____

Innovative Dentists

of Houston, PC

General & Cosmetic Dentistry

Patient Policies

Our goal as your dental care provider is to create a pleasant and comfortable experience both in the dental chair and at the financial desk. Please take some time to read over our **patient policies** so that we can establish a mutual understanding of situations that could take place. Whether the situation is financially related, insurance related, or appointment related, we want to ensure that you will leave our office with a smile on your face.

Financial Policy

We are a fee-for-service practice and payment is due at the time services are rendered. The fees indicated on your treatment plan are valid for six months; thereafter, the fees are subject to change.

We accept cash, checks, debit, and all major credit cards and there is a \$30.00 fee for any returned checks.

If you have an outstanding balance for longer than 120 days, your account will be turned over to a collection agency. You will receive a notice on your statement once the balance is 90 days old.

Insurance Policy

If you have insurance, the portion or percentage, not covered by the insurance company, and any deductible to be applied, is your responsibility and will be due at the time services are rendered. Please understand these fees are estimated according to the information given to us by your insurance company.

As a courtesy to our patients, we will file any and all dental insurance claims for you at the time treatment is performed in this office. Our office will provide the insurance company with all information they need to accurately process and pay your claim. Payment is normally received within 30 days from the date filed, however if we do not receive payment from the insurance company within 60 days, you are responsible for the total amount of your bill. Once we receive the insurance payment we will reimburse you the amount paid by your insurance.

We do not accept secondary insurance coverage, but our office will provide you with all of the information you will need to file the secondary claim yourself.

Although we verify the details of your policy's coverage, the information we receive from the insurance company does not guarantee the insurance will pay towards all treatment recommended and performed. If for some reason your insurance claim is denied or the insurance does not pay for a certain procedure, you are responsible for the amount not paid by the insurance.

If there are any changes to your insurance coverage please let us know at least two days before your appointment. If we are not made aware of changes you will be responsible for all charges incurred at the appointment. We will then verify the new coverage and file the claim according to the changes and you will be reimbursed the amount the insurance pays once we receive the insurance payment.

Appointment Policy

If you are late for an appointment there is a possibility that we may not have sufficient time to complete the treatment scheduled. In that case we will schedule another appointment to take care of the remaining treatment.

If you are more than 30 minutes late for your appointment, it will be cancelled and rescheduled to another day, and there will be a \$40.00 charge assessed to your account.

If you need to cancel or reschedule an appointment, please let us know 48 hours in advance. If an appointment is cancelled or rescheduled within those 48 hours, \$40.00 will be charged to your account.

Miscellaneous

A parent/guardian must be present at all times when treatment is being performed on children younger than 18 years old.

In order for our office to request and transfer your past records from another office, you will need to sign a Release of Records consent form. If you are transferring your dental care to another dentist, we request that you give our office two business days to prepare records and x-rays. Any duplication of records or x-rays will incur a duplication fee.

Before any treatment is rendered you will be required to sign a consent form which will detail the type of treatment being performed; list risks, options, conditions, and any post-op instructions for the type of treatment being performed; and will give the doctor your consent to perform the treatment.

If there are any changes to your personal information (i.e., health, address, phone numbers, employer, insurance) please let us know as soon as possible so that we may update your records.

If you have an unpleasant experience at our office or with one of our team members, please let us know so that we can rectify the situation and take necessary action to ensure that the situation that caused the unpleasant experience does not recur.

I have read all of the Patient Policies listed above. I understand and accept that it is my responsibility to follow through with the requests that have been made of me in order to maintain a working relationship with the dentist. I also understand that if any of the above situations were to occur they would be handled according to the Patient Policies.

Patient Signature: _____

Date: _____

Office Representative: _____

Date: _____

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 and 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 01/01/2006 and will remain in effect until we replace it.

We reserve the right to change our policy practices and the term 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 affective 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, and 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.

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 (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

Notice of Privacy Practices

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.

As 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, counter intelligence, 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 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. If you request copies, we will charge you a \$3.00 for each page, \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you requested 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.

Restrictions: 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.

Notice of Privacy Practices

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 question 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, ou may complaint to us using the contact information listed at the end of this Notice. You also may submit a written 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:

Telephone Number: 713-864-1315

Fax: 713 864-7431

E-mail:

Address: 427 West 20th St. Suite 400, Houston TX 77008