Active Life Dentistry®

Patient Information:

Last Name: | First Name: | Middle Initial:

How do you wish to be addressed?:

Social Security: | Date Of Birth: | Sex: ☐ M ☐ F | Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐

Email Address: | Cell Phone Number:

Home Address: | City: | State: | Zip Code:

Address 2: | Home Phone Number:

Employer Information:

Employer: | Occupation:

Work Address: | Work City: | WorkState: | Work Zip Code:

Work Address 2: | Work Phone Number:

Emergency Contact:

Emergeny Contact: | Relation: | Phone:

Guarantor or Responsible Party:

Name: | Relationship to Patient:

Address (if different from above): | City: | State: | Zip Code:

Social Security of Responsible Party: | Home Phone Number:

Insurance Information

Name of Insurance Company: | Phone Number:

Address: | City: | State: | Zip Code:

Policy Number: | Group Number

Active Life Dentistry®

Medical History

☐ Yes	☐ No	Are you under a physician's care?	For Staff Use Only
		Physicians Name: _____	Add Any Yes to the patient's Medical Problems in Medical Window, Add Allergies to Allergies
		Telephone: _____	
☐ Yes	☐ No	Are you currently taking any medications or substances? 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; i.e. penicillin, amoxicillin?	Also type in Med Urgent
☐ Yes	☐ No	Are you sensitive to metals or 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?	Select Premedicate in Medical Window
☐ Yes	☐ No	Do you have a pacemaker?	
☐ Yes	☐ No	Do you have high blood pressure?	
☐ Yes	☐ No	Have you ever had a serious illness?	
☐ Yes	☐ No	Have you ever had a major surgery?	
☐ Yes	☐ No	Have you ever had radiation therapy? In the head and neck area?	Type "No Extractions" in Med Urgent
☐ Yes	☐ No	Do you have artificial joints or prosthesis?	Select Premedicate, Need consult with Orthopedic if pt doesn't want to pre-med
☐ Yes	☐ No	Do you bleed excessively after being cut or injured?	
☐ Yes	☐ No	Are you diabetic?	
☐ Yes	☐ No	Have you tested positive for HIV or diagnosed with AIDS?	Type "No Benzo" in Med Urgent
☐ Yes	☐ No	Do you have acute narrow angle or untreated untreated open angle glaucoma?	Type "No Benzo" in Med Urgent
☐ Yes	☐ No	Do you smoke, chew or use any other form of tobacco?	
☐ Yes	☐ No	Do you have any disease, condition, or problem not listed here? Please explain.	

I understand that an accurate medical history is necessary for my dentist and his/her staff to be able to diagnose and treat me properly (including prescribing appropriate medications) and performing other dental services. I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my dentist, or any other member of his/her staff, responsible and hereby release and hold each of them harmless, on behalf of myself, my heirs and assigns, for any errors or omissions that I may have made in completion of this form

Patient Name: _____

Signature or Guardian's Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

HIPA Compliance: Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES FOR THE OFFICES OF

Active Life Dentisty

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

Active Life Dentisty

Of our office at

13611 Skinner Road
Suite 220
Cypress, Texas 77429
281-970-4000

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, 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 outside 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 information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

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.

Treatment Alternatives
We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

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 be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

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.

HIPAA Compliance: Notice of Privacy Practices

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

Research
We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

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 wouldnot object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse 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 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. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

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. You must submit a written request to:

Active Life Dentisty (use same address as above)

in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

HIPAA Compliance: Notice of Privacy Practices

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. To obtain this list, you must submit your request in writing to:

Active Life Dentisty (use same address as above)

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 Form Information to:

Active Life Dentisty (use same address as above)

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 example, 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:

Active Life Dentisty (use same address as above)

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. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact:

Active Life Dentisty (use same address as above)

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

Active Life Dentisty (use same address as above)

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ACKNOWLEDGMENT 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.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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 acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____

Financial Policy & Appointment Policy

Your understanding of our financial responsibility policy and appointment policy is an essential element of us being able to provide the best possible dental care and service to you and your family. Due to **changes in healthcare laws**, we have updated the policies. (Please read and initial EACH item below):

Insurance

_____ You are ultimately responsible for knowing what your plan does and does not cover, and administrative rules that apply (i.e.: in-network/out of network: out of pocket balance, copayment, 6-12-24 waiting periods, deductible,)

_____ Each patient is encouraged to verify if specific procedures are covered or not covered (missing tooth clause, downgrades to cheaper procedures.) and the percentage that each procedure is covered at, such as 100%, 80%, 50%.

_____ As a courtesy, we will 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 and our office for further explanation.

_____ Failure to inform and provide us with your current or new insurance information and/or reply back to insurance's request for additional information may result in the entire bill being your responsibility. (We may not be on your new insurance, and therefore not eligible for various discounts)

General

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

_____ Independent specialists whom we may refer you to (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 (i.e.: automobile insurance). Your visit will be self-pay and a receipt will be given to you to file with your auto insurance. Our office does not accept workman's compensation cases.

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

Fees

_____ There is a $25 filing fee for predetermination of benefits.

_____ 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 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, ultimately you may be asked to reschedule.

_____ Please notify 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: