WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's SS#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

____
CITY STATE ZIP

Phone #: (____) ____

Insured's SS#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

GEALON A. THOMAS, DDS, PLLC

DATE

MEDICAL HISTORY

FOR

--MEDICAL HISTORY

Birth Date:

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 you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No _____

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

GEALON A. THOMAS, DDS, PLLC

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
b) Obtaining payment from third party payers (e.g. my insurance company);
c) The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your **Notice of Privacy Practices,** ***which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.***

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ ***Relationship:*** _____

Signature: _____ ***Date:*** _____

GEALON A. THOMAS, DDS, PLLC
FINANCIAL POLICY

THANK YOU FOR CHOOSING THIS OFFICE AS YOUR DENTAL PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT FOR YOUR SERVICES IS PART OF YOUR TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO TREATMENT.

ALL PATIENTS MUST HAVE A COMPLETED SET OF NECESSARY PAPERWORK WHICH INCLUDES PATIENT INFORMATION, HEALTH HISTORY, RESPONSIBLE PARTY, INSURANCE, HIPAA, AND FINANCIAL INFORMATION BEFORE BEING SEEN BY THE DOCTOR AND/OR STAFF MEMBER PROVIDING TREATMENT.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, AND DISCOVER, CHECKS AND CASH. WE ALSO OFFER THE CARE CREDIT PROGRAM (WITH APPROVED CREDIT).

REGARDING INSURANCE
WE WILL, AS A COURTESY, FILE MOST ALL DENTAL INSURANCE CLAIMS FOR YOU. HOWEVER, YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY OF THAT CONTRACT. WE WILL NEED YOUR FULL INSURANCE INFORMATION, INCLUDING A CARD COPY WITH THE POLICY HOLDER'S FULL INFORMATION. THE FULL NAME, DATE OF BIRTH, SOCIAL SECURITY #, ID #, PLACE OF EMPLOYMENT, TELEPHONE NUMBER(S) AND MAILING ADDRESS. ALL CO-PAYMENTS AND DEDUCTIBLES ARE TO BE PAID AT THE TIME OF SERVICE. IF INSURANCE HAS NOT PAID YOUR CLAIM WITHIN 45 DAYS, YOU WILL BE RESPONSIBLE FOR THE BALANCE AT THAT TIME. PLEASE BE AWARE THAT SOME AND PERHAPS ALL OF THE SERVICES PROVIDED MAY BE CONSIDERED NOT REASONABLE AND NECESSARY BY YOUR INSURANCE AND WOULD BE CONSIDERED AS A NON-COVERED SERVICE UNDER YOUR INSURANCE PLAN. OUR OFFICE WILL TRY TO PROVIDE A TREATMENT ESTIMATE FOR YOU; HOWERVER, THE ESTIMATE IS NOT A GUARANTEE OF PAYMENT AND IN NO WAY HOLDS OUR OFFICE RESPONSIBLE FOR THE AMOUNT(S) NOT PAID BY YOUR INSURANCE COMPANY. YOU ARE RESPONSIBLE FOR ALL CHARGES NOT COVERED/PAID BY YOUR INSURANCE COMPANY.

REGARDING INSURANCE PLANS IN WHICH WE ARE CONSIDERED A PARTICIPATING PROVIDER, ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED. SHOULD YOUR INSURANCE COMPANY CHANGE TO A PLAN IN WHICH WE DO NOT PARTICIPATE, PLEASE REFER TO THE ABOVE PARAGRAPH.

USUAL AND CUSTOMARY RATES
OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT IS USUAL AND CUSTOMARY FOR OUR AREA. YOU ARE RESPONSIBLE FOR PAYMENT OF ALL CHARGES REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

ADULT PATIENTS
ALL ADULT PATIENTS ARE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE.

MINOR PATIENTS
THE ADULT ACCOMPANYING A MINOR AND THE PARENTS (OR GUARDIANS OF THE MINOR)) ARE RESPONSIBLE FOR FULL PAYMENT. WE ALSO MUST HAVE A COMPLETE SET OF PAPERWORK COMPLETED IN FULL AND SIGNED BY THE PARENT(S) AND/ OR LEGAL GUARDIAN(S) OF THE MINOR PRIOR TO ANY TREATMENT DONE. WE MUST HAVE VERIFICATION OF AUTHORIZED PAYMENT PRIOR ANY SERVICES RENDERED. PLEASE NOTE: IN CASES WHICH THE PARENTS ARE DIVORCED, WE ARE NOT A PARTY OF ANY DIVORCE SETTLEMENT REGARDING ANY COURT ORDERS AS TO WHO WILL BE RESPONSIBLE FOR THE CHARGES. ALL PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED REGARDLESS OF ANY COURT ORDERS.

MISSED APPOINTMENTS
UNLESS CANCELLED, AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT THE RATE OF A REGULAR OFFICE VISIT. PLEASE NOTE: OUR ANSWERING SERVICE IS NOT AUTHORIZED TO ACCEPT CANCELLATIONS. PLEASE HELP US SERVE YOU BETTER BY KEEPING YOUR SCHEDULED APPOINTMENTS. WHEN APPOINTMENTS ARE CANCELLED AT LAST MINUTE OR YOU SIMPLY NO SHOW YOUR APPOINTMENT, YOU HAVE TAKEN AN APPOINTMENT TO WHICH ANOTHER PATIENT COULD HAVE BEEN APPOINTED.

INTEREST
WE RESERVE THE RIGHT TO CHARGE INTEREST IN THE AMOUNT OF 15% AS PROVIDED BY STATE LAW.

REGARDING COLLECTION SERVICES
IN THE EVENT THAT YOUR ACCOUNT BALANCE IS UNPAID, IT WILL BE SENT TO AN OUTSIDE AGENCY FOR COLLECTIONS. YOU WILL BE RESPONSIBLE FOR ANY COLLECTION AGENCY FEES. A 40% CHARGE WILL BE ADDED TO YOUR BALANCE FOR THE COLLECTION AGENCY FEES. (YOU WILL ALSO BE RESPONSIBLE FOR ALL COURT COSTS SHOULD THEY OCCUR).

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS. WE WILL BE HAPPY TO DISCUSS ANY QUESTIONS YOU MAY HAVE.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE: _____ DATE: _____

SIGNATURE : _____ DATE: _____

IF MINOR, SIGNATURE OF PARENT AND/OR LEGAL GUARDIAN REQUIRED.

GEALON A. THOMAS, DDS, PLLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT CONSENT

Patient Name: _____ ***SS #:*** _____-___-_____

Section B: TO THE PATIENT- PLEASE READ THE FOLLOWING:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities, and day- to- day 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 disclosure we may make of your protected health information, and of other important matters concerning your protected health information. A copy of our Privacy Practices is provided with 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.

SIGNATURE

I have had full opportunity to read and consider the contents of this consent form. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information so your practice may carry out treatment, payment activities, and day-to-day healthcare operations.

Signature: _____ ***Date:*** _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following information:

Print Personal Representative Name: _____

Relationship to Patient: _____

Signature: _____ ***Date:*** _____

You have the right to revoke this consent to disclose your protected health information at any time. This request must be sent to us in writing.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature: _____ ***Date:*** _____

I have read and understand this office's Notice of Privacy Practices. I do not wish to obtain a copy for my records at this time.

Signature: _____ ***Date:*** _____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: _____ ***Date:*** _____

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.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on 4/2003.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or from us or by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint.