—CENTER OF ENDODONTICS—
PERIODONTICS AND IMPLANTOLOGY

MEDICAL ALERT:

PATIENT MEDICAL HISTORY

PATIENT NAME _____

GENERAL DENTIST NAME _____ **Date of Last Visit** _____

PHYSICIAN'S NAME_____ **Date of Last Visit** _____

Have you had any serious illnesses or operations? _____ **If yes, describe** _____

Check (×) if you have had problems with any of the following:

__Bad breath __Grinding teeth __Periodontal treatment
__Bleeding gums __Loose teeth or broken fillings __Sores or growths in your mouth
__Sensitivity to hot/cold __Sensitivity to sweets __Sensitivity when biting

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) __ Yes __ No

(Women) Are you pregnant? __ Yes __ No **Nursing?** __ Yes __ No **Taking birth control pills?** __ Yes __ No

Are you taking (or have taken) any oral or IV bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.)? __ Yes __ No

Check ( ) if you have or have had any of the following:

__Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Blood Disease
__Cancer
__Chemotherapy
__Circulatory Problems
__Cortisone Treatment
__Cough, Persistent
__ Cough up Blood
__ Diabetes
__ Epilepsy
__ Fainting
__ Food Allergies
__ Glaucoma
__ Headaches
__ Heart Murmur
__ Hemophilia
__ Hepatitis
__ Herpes
__ High Blood Pressure
__ HIV/AIDS
__ Jaw Pain
__ Kidney Disease
__ Liver Disease
__ Material allergies (latex,wool, metal chemicals)
__ Mitral Valve Prolapse
__ Nervous Problems
__ Psychiatric Care
__ Rapid Weight Gain or Loss
__ Radiation Treatment
__ Respiratory Disease
__ Shingles
__ Shortness of Breath
__ Skin Rash
__ Stroke
__ Swelling Feet/Ankles
__ Surgical Implant
__ Thyroid Problems
__ Tonsillitis
__ Tuberculosis
__ Ulcer/Colitis

MEDICATIONS

List medications you are currently taking: _____

_____

_____

PHARMACY: _____

ALLERGIES

__ Aspirin __ Penicillin
__ Sulfa __ Barbiturates (Sleeping pills)
__ Codeine __ Latex_____
__ Local Anesthetic __ Other_____

DOCTOR'S COMMENTS: _____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Alicia Gray and/or Dr. Fatima Robertson, if I, or my minor child, ever have a change in health.

SIGNATURE

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

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PATIENT INFORMATION

Patient Name _____ ☐ Male ☐ Female

Address _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____ Mobile _____

E-Mail _____ Work Phone _____

How do you prefer to be contacted? _____

Date of Birth _____ _____

Emergency Contact _____ _____

I authorize the release of medical information to the following individual: _____

FINANCIAL POLICY

Payment of services is due at the time services are rendered. We accept cash, check, and credit cards.
All checks will be processed electronically. There will be a **$50.00** fee charged for returned checks if we are unable to process electronically.
Your insurance policy is a contract between you, your employer and the insurance company. We are **not** a party to that contract. Our involvement will be limited to supplying factual information to facilitate claim processing. All charges are your responsibility whether your insurance company pays or does not pay.
Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.
If your insurance company does not pay your claim in 30 days, it is your responsibility to contact your insurer to expedite payment. **If your insurance does not pay, you are responsible for your payment**. If your insurance company does not pay in full within 45 days, we require you to pay the balance. Balances older than 60 days may be subject to collection placement and fees.
A. I authorize payment from my insurance carrier be made directly to Dr. Alicia R. Gray/ Dr. Fatima Robertson.
B. I authorize this office to release necessary medical and/or dental information.
Thank you for choosing this office for your endodontic/periodontal treatment. We appreciate your trust in us and the opportunity to serve you.

Patient or Guardian Signature **Today's Date**

_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 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) _____

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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 07/01/05, 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. If you request copies, we will charge you $0.25 for each page and $5.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request 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.

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.

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

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.

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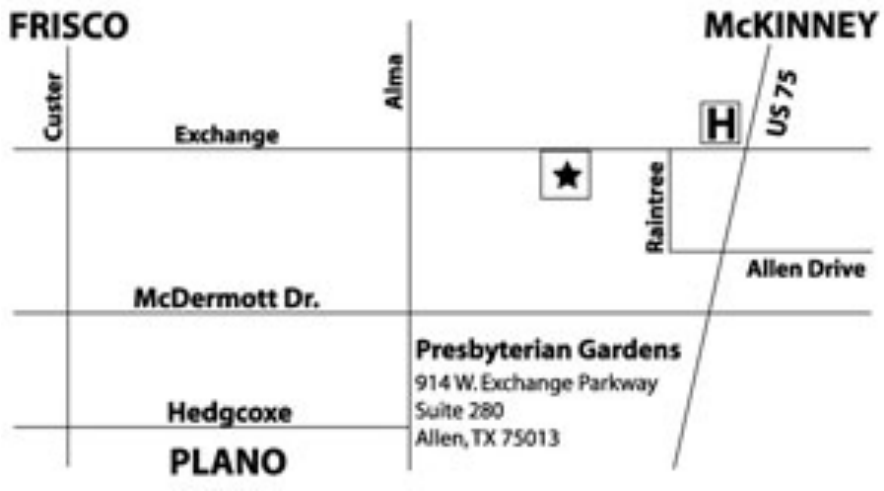
OFFICE DIRECTIONS:



From Frisco/Hwy 121:
From Hwy 121, take the ***Exchange Parkway/Custer/Alma Exit***. Turn right on Exchange and go approximately two miles… passing ***Alma*** (CVS Pharmacy on the left); passing ***Bray Central***; passing ***Watters Creek***; passing ***Junction***. The Presbyterian Gardens Complex is the one-story medical office building located immediately to your right. The address is ***915 West Exchange Parkway*** and we are in Suite No. 280.

From Dallas/Richardson/Plano:
From Hwy 75 take the ***Exchange Parkway Exit No. 36***--heading west; turn right going back over the overpass; passing the Texas Presbyterian Hospital of Allen on the left; passing ***Raintree***; passing the Presbyterian Gardens Complex, make a u-turn and come back into the Presbyterian Gardens Complex, a one-story medical office building, located immediately to your right… The address is ***915 West Exchange Parkway*** and we are in Suite 280.

From Sherman/McKinney:
From Hwy 75 take the ***Exchange Parkway Exit No. 36***--heading west; passing the Texas Presbyterian Hospital of Allen on the left; passing ***Raintree***; passing the Presbyterian Gardens Complex, make a u-turn and come back into the Presbyterian Gardens Complex, a one-story medical office building, located immediately to your right… The address is ***915 West Exchange Parkway*** and we are in Suite 280.