PATIENT INFORMATION

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Date ________________

Patient's Name ____ Gender _________

Last | First | Middle | Nickname

Address ____

Street | City | State | Zip Code

________ ________ ________ ________ ________

Home Phone | Work Phone | Social Security | E-Mail | Birth Date

________ ________ ________ ________

Spouse's name | Spouse's employer name | Spouse's Work Phone | Spouse's Social Security

GUARANTOR INFORMATION (If different from above): RELATION TO PATIENT: _________________

Name____________________________________Marital Status_________________

Last | First | Middle

Address ____________________________________Birth date___________________

Street | City | State | Zip Code

Home Phone____________ Work Phone_______________SS#__________________DL#________________

Employer___________________________Occupation__________________ Number Years Employed________

EMERGENCY NOTIFICATION INFORMATION

In case of emergency, please notify:

Name______________________________Address_____________________________Phone________________

Name______________________________Address_____________________________Phone________________

I plan to take care of my financial responsibility by:

[ ] CASH [ ] CHECK [ ] BANK CARD: [ ] MasterCard [ ] American Express
[ ] Visa [ ] Discover

Purpose of Visit___________________________________**Last Dental Visit**____________________________

Whom may we thank for referring you? ____

* If you have third party reimbursement, we are happy to help you maximize your benefits. We will ask that you take care of all fees at the time of service. We will submit your claim for you, assigning payment to you. Because we file claims electronically, you can expect prompt payment from your third party administrator.

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE ATTACHED INFORMATION FORM

MEDICAL QUESTIONNAIRE **(circle One)**

1. Have you been a patient in the hospital during the past two years?... YES NO
2. Have you been under the care of a medical doctor during the past two years?........................... YES NO
   Your Physician's Name____
   Address ________________________________Phone No.________________
   When was your last complete Medical physical?____________________________
3. Have you taken any medicine or drugs during the past two years?.. YES NO
   Are you now taking any medication, drugs or pills?... YES NO
   If yes, please list:____
   ____
4. Are you allergic or have you reacted adversely to any of the following medications?................ YES NO
   (If YES, please circle)

Aspirin	Nitrous Oxide	Valium/Halcion	Local Anesthetic (Novocain or Xylocaine)
Darvon	Erythromycin	Scopolamine	General Anesthetic
Codeine	Tetracycline	Penicillin	IV Anesthetic
Demerol	Percodan	Other Antibiotics	Sleeping Pills (Nembutal/Seconal)

5. Are you aware of being allergic to any other medications or substance?................................... YES NO
   If yes, please list:____
6. Circle any of the following, which you have had or have at present:

Heart Failure	Emphysema	HIV/AIDS	Prostate Problems
Heart Disease or Attack	Cough/Persistent	Hepatitis A (infectious)	Multiple Sclerosis
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)	Mouth Ulcers
High Blood Pressure	Asthma	Liver Disease	Alcoholism
Heart Murmur	Hay Fever	Yellow Jaundice	Drug Dependency
Rheumatic Fever	Sinus Trouble	Blood Transfusion	Cancer/Tumors
Congenital Heart Lesions	Allergies or Hives	Drug Addiction	Epilepsy or Seizures
Scarlet Fever	Diabetes	Hemophilia	Arthritis
Artificial Heart Valve	Thyroid Disease-Hyper/Hypo	Cosmetic Surgery	Bruise Easily
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores	Fever Blisters
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Fainting or Dizzy Spells	Anemia
Stroke	Rheumatism	Nervousness	Pain in Jaw Joints (TMD)
Kidney Trouble	Cortisone Medicine	Psychiatric Treatment	Glaucoma
Stomach Ulcers	Sickle Cell Disease	Venereal Disease (Syphilis, Gonorrhea, Herpes)	
Artificial Joints (Hip, Knee)			

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath or because you are very tired?.. YES NO
8. Do your ankles swell during the day?.. YES NO
9. Do you use more than two pillows to sleep?.. YES NO
10. Have you lost or gained more than 10 pounds in the past year?... YES NO
11. Do you ever wake up from sleep short of breath?.. YES NO
12. Are you on a special diet?.. YES NO
13. Has your medical doctor ever said you have a cancer or tumor?... YES NO
14. Do you have any disease, condition, or problem not listed?... YES NO
    If YES, please explain____

FOR WOMEN ONLY:

Are you pregnant? Yes No If YES, what month? ____ Are you taking birth control pills? YES NO

Are you taking hormone medication YES NO

I certify that the above information is true and correct: ________________________________ ______________

Patient's Signature Date

CONSENT:

The undersigned hereby authorizes Dr. Dickson to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Dickson to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Dickson to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ______________________________ and further authorize and consent that Dr. Dickson choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Patient_______________________________________Date__________Witness ______________________
Parent or Responsible Party___________________________________Relationship to Patient _________________

DENTAL QUESTIONNAIRE

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____

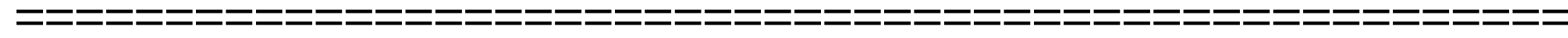
First Name Middle Last Nickname

Please answer the following questions accurately to permit Dr. Dickson to treat you appropriately based on your particular needs. Your answers will be considered confidential and are for our records only.

		YES	NO
1.	Are you having any discomfort at this time?	[ ]	[ ]
2.	Have you ever had any unpleasant experiences associated with previous dentistry?	[ ]	[ ]
3.	Does dental treatment make you nervous?	[ ]	[ ]
4.	What was done at your last dental visit? ____ ____		
5.	Have you ever been treated for periodontal/gum disease? If Yes, what type of treatment______ ____	[ ]	[ ]
6.	How often do you brush?______________________ Type of brush: soft______medium______hard____		
7.	How often do you floss?_______________________		
8.	Do you have, or have you ever had, any of the following?		

	YES	NO
Bleeding sore gums	[ ]	[ ]
Unpleasant taste/bad breath	[ ]	[ ]
Burning tongue/lips	[ ]	[ ]
Frequent blisters/lips, mouth	[ ]	[ ]
Swelling, lumps in mouth	[ ]	[ ]
Orthodontic treatment (braces)	[ ]	[ ]
When: _________________________		
Clicking/popping jaw	[ ]	[ ]
Change in bite/the way your teeth come together	[ ]	[ ]
Difficulty in opening or closing mouth	[ ]	[ ]
Loose teeth	[ ]	[ ]
Sensitivity to: hot____cold____sweets____biting____		
Food packing in between teeth	[ ]	[ ]

SATISFACTION LEVEL



Please check the appropriate boxes:

1. My mouth is... [ ] very comfortable
   [ ] moderately comfortable
   [ ] uncomfortable

2. I . . . [ ] am satisfied with the appearance of my smile.
   [ ] am dissatisfied with the appearance of my smile.

3. I . . . [ ] have set goals for my oral health with a previous dentist
   [ ] want to set goals concerning my dental health

4. I . . . [ ] have put dentistry for myself and family high on my priority
   [ ] have put dentistry for myself and family low on my priority
   [ ] dentistry is on my list, but it's hard to find

5. I think my present state of dental health is:

   [ ] excellent
   [ ] good
   [ ] poor

6. Please list anything you would want to change about your smile.
   ____
   ____
   ____

7. These are the things that are important to me about my dental health:
   ____
   ____
   ____

8. What I expect from my dentist:
   ____
   ____
   ____

10. What are some questions about dentistry and oral health that you have never had adequately answered?
   ____
   ____

ORIENTATION FORM

We are pleased that you have chosen our office for your dental needs. Below is information provided to assist you in understanding our services and to help familiarize you with our office.

Our office hours are from 7:30 AM to 3:00 PM on Monday and Thursday. On Tuesday and Wednesday, we are here from 7:30AM to 4:30 PM, with lunch from 12:30 to 1:30. Our Friday hours are always on the last Friday of the month from 8:00 AM to 2:00 PM. Please call our office for further instructions in emergency situations after office hours.

All fees are due from the patient at the time of service. If you have dental insurance, we will help you maximize your benefits by filing your claims for you. You will receive a reimbursement directly from your insurance company for whatever you are entitled to. Ultimately, it is the patient's responsibility to provide our office with current, accurate insurance information. This includes provisions on your policy, which may not pay for some services provided by our office. While we are happy to assist you in following up with your insurance company, writing appeals and necessary narratives for payment, this is offered as a courtesy to you.

We realize that with larger treatment plans, payment arrangements may be necessary. Financing options are available through Dental Fee Plan and Care Credit. Our office will provide you with this information and discuss other ways to make the dentistry you need affordable to you.

We believe all treatment started should be completed. Incomplete treatment leads to problems, misunderstandings and usually further disease. Therefore, if a plan is agreed upon and started, it needs to be completed. We will do our best to design your treatment plan to fit your needs, while not compromising your dental health. More extensive cases may need to be phased over several appointments. Others may only require one appointment to complete. Please remember that our office does not diagnose treatment based on what your insurance company will pay. Our primary goal is to give you the best possible oral health with a treatment plan agreeable to all involved.

Beyond our most calculated efforts, further necessary treatment may arise during a dental procedure that was not originally diagnosed. This treatment will incur additional fee's that you will be responsible for. Should this situation arise, Dr. Dickson will inform you of these changes.

If you are ever unable to keep an appointment you have scheduled with us, please notify us at least 48 hours (no less than 2 business days) in advance. This allows us the opportunity to see another patient, who may wish to fill that open time. We reserve the right to charge a $50 fee for all missed appointments and short notice cancellations. If a history of short notice cancellations or "no shows" has been established, you may be required to pre pay for your dental visits before being rescheduled.

For your convenience, we accept American Express, MasterCard, Discover, Visa, checks and cash.

I have read, understand and agree to the above information.

____ ___________________________

Signature Date

Due to the great inconsistency in telephone confirmations, our office cannot guarantee the benefit information we are given by your insurance company. We have found that you as the insured are better able to secure information from insurance booklets, human resource personnel, or by directly contacting the insurance company. We recommend that you always note the names of representatives you communicate with, should there be any discrepancies in the benefits provided and those promised to you.

If you have insurance, please provide us with the information requested below:

Patient Name: ____________________________ Policy Holder: ____________________

Employee SS# _____________________ Employee Date of Birth: _________________

Employer: ____ Group #: __________

Insurance Company Name: ____________________________ Phone #_______________

Insurance Filing Address: ____

Electronic Filing Code: _____________________ *(the Payor ID # for NEIC Claims)*

To help you better understand your insurance, please call your insurance company and ask the following questions:

Effective date: ___________ Deductible: __________ Yearly Maximum: ___________

Has the deductible been met: _________ Benefits Remaining this year: _____________

What is the percentage breakdown for the following:
Preventative ______% Deductible applied? _______ Perio _________%

Basic _______ % Deductible applied? ________ Endo __________%

Major _______% Deductible applied? _________ Oral Surgery __________%

Ortho _______% Deductible applied? __________ age limit? _______

What is the frequency on the following?

Cleanings ____________ Exams ________ Bitewing x-rays _____________

Full mouth x-rays ___________ Fluoride Treatment ____________ age limit? ______

Are there any waiting periods on any services? _________________________________

Missing tooth clauses? _____________ Replacement clause? _______ How many years after replacement? __________

Are there any benefits for occlusal guards for TMJ or for bruxing habits? _____________

Are there any benefits for Adjunctive pre-diagnostic test?(D0431) ______________

Please bring this completed form with you to your initial visit. Thank you.

Some Facts About Dental Insurance

Over 50% of patients seeking dental care have some type of Dental Insurance – or dental "assistance", as it should be called. Unlike medical insurance, dental insurance is designed to pay only a *portion* of the cost of dental treatment.

Your employer has made this coverage available to you, and the type of benefit you receive depends upon the type of contract that was chosen with the insurance company. Your employer buys a special contract at a special fee (or premium) and includes as many or as few benefits as the employer is willing to pay for. Keep in mind that your dentists fees or services are in no way reflective of what your insurance deems to be "Usual and Customary" by your insurance company, because remember…your employer selected your plan for you, not your dentist.

Benefits vary from policy to policy and the premiums that are paid are usually reflective of your individual plan.
(i.e. Higher premium = Higher usual and customary rates and fewer exclusions and limitations)

Unfortunately it would be *impossible* for your dental office to determine each and every patient's policy provisions and limitations. While happy to assist you in filing your claims please keep in mind that is offered as a courtesy.

Occasionally there are services that are selected as "Non covered" services which vary from plan to plan and policy to policy.

Some services may include but are not limited to the following:

- Oral Hygiene Instructions
- Review of Findings
- Fluoride
- Sealants (Adults, Premolars, or Previously Sealed Teeth)
- Consultations / when done in conjunction with other services (i.e. Comprehensive Examination, FMX)
- Pulp Caps
- Composite (tooth colored) fillings
- Full Mouth Debridement
- Visilight Oral Cancer Screening
- Arestin

Your dental health should never be dictated by what your dental insurance will or will not cover. Please allow us the opportunity to answer any questions that you may have regarding your insurance coverage.

Patient Signature

Date

Plano Center for Aesthetic Dentistry

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 (MM/DD/YR), 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 $0.99 for each page, $25.00 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.

Contact Officer: Crystal Sand, Business Manager

Telephone: 972-644-5544 Fax: 972-398-2788

E-mail: Crystal@PCADentistry.com

Address: 3900 American Drive, Suite 201 Plano, Texas 75075

Plano Center for Aesthetic Dentistry

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.

____ _____________________________________

Patient 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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