Patient Acknowledgement of Receipt of our Notice of Privacy Practices

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims

Date_____________

The Undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practice for ______________________. A copy of this signed, dated acknowledgement shall be as effective as the original.

______________________________	______________________________
Please print your name	Please sign your name
______________________________	______________________________
Legal Representative	Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION

(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name_____________________________	Relationship_________________________
Name_____________________________	Relationship_________________________
Name_____________________________	Relationship_________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA

- Cell Phone Confirmation
- Home phone Confirmation
- Work Phone Confirmation
- Text Message to my Cell Phone
- Email Confirmation
- U.S Mail/Post Card

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA

- Message on Cell Phone
- Message on Home Phone
- Message on Work Phone
- Text Message
- Email Message
- U.S Mail/Postcard
- Any of the above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS OR NEW DENTAL INFO** VIA

- Phone Message
- Text Message
- Email
- U.S Mail/Postcard
- Any of the above

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives signature on this Acknowledgement but did not because

It was emergency treatment ______

I could not communicate with the patient ______

The Patient refused to sign ______

The patient was unable to sign because ______

Other (Please describe) ______

____

Signature of Privacy Officer

Dr. Jeena Samuel, DMD

738 F.M 1092 Stafford, Tx 77477

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to.

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third- Party Payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change this Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request retractions, but if you agree then you bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Signature______________________________ Date________________

Parent/Guardian______________________________ Date________________

Pay Understanding & Verification of Insurance

In signing this statement, I am fully aware that I am responsible for any chargès associated with any x-rays, exam, and treatment that is provided to me today. My signature conveys to The Smile Doctors, PA that I will take care of any financial responsibilities for treatment that is not paid for by the insurance company.

The smile Doctors, PA (Smile Dental) will attempt to collect for services from your insurance company on your behalf.

I am aware that Smile Dental or The Smile Doctors, PA (Smile Dental) will **ATTEMPT** to verify my insurance coverage on the date of service. Often time's dates of service are not updated immediately in insurances date bases, causing a delay in the conveyance of information. I am aware that it is my responsibility to be aware of what is covered and not covered in my employer provided insurance policy or private policy that I have enrolled in.

I am aware that in the case that my insurance company does not pay for a service that was provided to me. I will receive a bill for that amount from The Smile Doctors, PA (Smile Dental) for which I will fulfill the financial responsibilities of that bill.

____

Print Name of Patient

____

Signature of Patient or Parent/Legal Guardian of Patient

Time 3:49 PM

SMILE DENTAL, Stafford TX
Eaglesoft Medical History

Date 12/16/2016

Patient Name: Birth Date: Date Created:

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

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

- Pregnant/Trying to get pregnant?
- Nursing?
- Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
- Metal
- Penicillin
- Latex
- Codeine
- Sulfa Drugs
- Acrylic
- Local Anesthetics

Other?		If yes
Do you use controlled substances?	Yes No	If yes

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

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

Have you ever had any serious illness not listed Yes No If yes

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:

X

Date:_________

Patient Information

*First Name/Nombre________________________ *Last Name/Apellido ____________________

*D.O.B/Fecha de nacimiento_________________ *Male/Female Age/Edad______

*S.S#/Seguro Social___________________ Address/Direccion_________________________________

City/Ciudad______________ State/Estado_____________ Zip Code/Codigo postal___________

*Email/Correo Electronico________________________

*Home Phone/Telefono de casa _________________ Cell Phone/Celular____________________

Marital Status: /Estado Civil: Married/Casada(A) Single/Soltero(A) Child /Menor

Employer /Empleador______________________How Long/Cuanto tiempo __________________

Business Phone/Telefono de trabajo____________________

Insurance Information

Name of Insurance/Nombre de la aseguranza _______________ Phone Number/Telefono__________

Name of Insured/Nombre del Asegurado__________ _Insured S.S#/SeguroSocial _______________

Insured D.O.B/Fecha de nacimiento del asegurado______________

Employee/EmpleoHow Long/Cuanto tiempo___________________

Business Phone/Telefono del trabajo_____________________

Who will pay for this Account? /Quien pagara por la cuenta______________________________

Emergency Contact/Contacto de Emergencia____________________________

Emergency Contact #/# deContacto de emergencia ____

Are you under Physician's Care? /Esta al cuidado de un Doctor__________________________________

Physician's Name/Nombre del doctor____________________

Are you taking any Prescription Drugs? /Esta tomando un Medicamento__________________________

For What Purpose? /Cual es el proposito____

Welcome

Patient Name________________________________ Date______________________

How did you hear about our office?

Greensheet Newspaper_________

Subasta Newspaper_______

Azchavattom Newspaper_______

Voice of Asia Newspaper_______

Buena Suerte Newspaper______

Walk in/Sign Board_____

Other________________________

Referred by__________________________

Online Search_______

Website_______

Social Media_______

Flyer_______

Yellow Book________