TQD.D.S.TANSBERRY
Family & Cosmetic Dentistry

# *Patient Registration and Health History Form*

## PATIENT INFORMATION

Your Full Name _____ Social Security _____
Preferred Name _____ Driver's License _____
Your Address _____ Apartment _____
City _____ State _____ Zip _____
Date of Birth _____ Phone _____ Cell _____
Employer _____ Work Phone _____
Employer Address _____ Email Address _____
City _____ State _____ Employers Zip _____
Occupation _____

Contact in the event of an emergency _____
Emergency Contact's Phone _____

Marital Status ○ Married ○ Divorced ○ Single ○ Widowed

*If patient is a minor, please complete:*

Responsible Party's Name _____ Relationship _____
Address _____ Apartment # _____
City _____ State _____ Zip _____

List family members treated in this office _____
Whom may we thank for referring you to us? _____

## INSURANCE INFORMATION

***Insured Employee*** Social Security

Relationship (to patient) _____ Driver's License _____
Address _____ Apartment # _____
City _____ State _____ Zip _____
Date of Birth _____ Home Phone _____
***Employer*** _____ Work Phone _____
Address _____
City _____ State _____ Zip _____
***Insurance Co.*** _____ Group # _____
Address _____ Policy # _____
City _____ Phone # _____
State _____ Zip _____

I hereby authorize payment of the insurance benefits otherwise payable to me directly to Todd T. Stansberry, D.D.S. I acknowledge that I am responsible for the full amount of the fees incurred independent of any insurance.

**Signed** _____ **Date** _____

## CONSENT

The undersigned hereby authorizes Doctor to take X-rays. study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs, I also authorize Doctor to perform any and all forms of treatment medication and therapy, that may be indicated in connection with

**Patient Name** _____

and further authorize and consent that Doctor choose and employ such assistance as deemed fit.

**Signed** _____ **Date** _____

(If patient is a minor, parent or guardian must sign.)

## HEALTH HISTORY

Yes No 1. Are you in pain or discomfort at this time?

Yes No 2. Do you feel very nervous about dental treatment?

Yes No 3. Have you ever had a bad experience in a dental office?

Yes No 4. Have you been under the care of a medical doctor during the past two years?

Physician's Name _____ Phone _____

Address _____

Yes No 5. Have you taken any medication or drugs during the past two years?

Yes No 6. Have you ever taken the medication Phen-Fen?

Yes No 7. Are you now taking any medication, drugs or pills? If so, please list:

Yes No 8. Are you aware of being allergic to or having an adverse reaction to any medication or substance?

If yes, please list: _____

Yes No 9. Has your medical doctor ever said that you have cancer or a tumor? If so, what kind?

10. Indicate which of the following you have had or have presently:

- ☐ A.I.D.S.
- ☐ Allergies or Hives
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint Replacement
- ☐ Asthma
- ☐ Blood Transfusion I
- ☐ Bruise Easily
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Congenital Heart Lesion
- ☐ Cortisone Medicine
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Heart Disease or Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (Serum)
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Trouble
- ☐ Liver Disease or Jaundice
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble or Hayfever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Venereal Disease

Yes No 11. Do you have any disease, condition, or problem not listed above? _____

## FOR WOMEN ONLY

Yes No 12. Are you pregnant? If so, what month? _____

Yes No 13. Are you taking birth control pills?

## DENTAL HISTORY

Yes No 14. Do you have or have you had pain in the jaw joints?

Yes No 15. Do your gums ever bleed?

Yes No 16. Are your te eth sensitive to chewing, hot or cold?

Yes No 17. Have you ever had periodontal (gum) treatment?

Yes No 18. Do you grind your teeth?

Yes No 19. Are you satisfied with the appearance of your teeth?

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I do hereby certify that all statements answered are accurate and true.

**Print Name** _____ **Date** _____

**Signed** _____ **Date** _____

# Todd T. Stansberry D.D.S.

5501 Independence Pkwy, Suite 200 Plano, TX 75023

The following policies have been put into effect by our office regarding payment of dental fees. These policies are designed to reduce expensive paperwork and secretarial services , which may otherwise force us to raise charges to our patients. Your cooperation is appreciated.

1. OFFICE VISITS - Payment is expected at the time services are rendered . However, if the balance is over $100, we will help you by filing your insurance for the covered portion . The deductibles and non-covered portion is due at the time of service. For your convenience, we accept MasterCard, Discover, and Visa.

2. ROUTINE CLEANINGS - Most insurance plans cover 80-100 % of your cleanings. Some insurance policies have deductibles, some do not. If you have your insurance form completed and signed we will, as a courtesy to our patients, file your insurance for the cleaning, x-rays, and exam. If your cleaning happens to come near a billing cycle, you may receive a statement for those services. This is just to let you know the stat us of your accounts, and it may reflect some outstanding charges. If your insurance does not pay within sixty days, you will be responsible for those charges. It will then be up to you to contact your insurance carrier about any problem with payment .

3. DENTAL INSURANCE - Dental Insurance plans vary widely in their coverage of services. Your contract is an agreement between you and the insurance company. This contract does not obligate the doctor to charge a specific fee or to accept reimbursement from your insurance company as payment in full. You will remain responsible for the unpaid balance. Complaints or inquiries about insurance coverage should be directed to your insurance agent. Any insurance filing on your behalf done by this office is a courtesy, not a requirement. * Effective January 1, 1995, we will now only file with your primary insurance carrier. I n the event that you have coverage with more than one company, it will be your responsibility to file directly to them . In addition, any amounts not paid by your primary insurance company will be your responsibility to pay to this office.

4. INSURANCE CHECKS- Should your insurance company send your reimbursement check to us, we will make every effort to sign th e check over when possible.

5. NO-SHOW POLICY - We require a twenty-four hour notice to reschedule or cancel an appointment. We normally confirm your appointment twenty-fours in advance by phone. Our no-show policy fee for a broken appointment is $35.00. We do understand that things beyond your control can happen. If this is the case, please call. We understand your time is valuable and make every effort to see you at your scheduled time.

6. PAST DUE ACCOUNTS - All charges are payable within sixty days. If your account becomes past due, we will take necessary steps to collect this debt. Unpaid accounts will be referred to a professional collection agency, the Credit Bureau, and small claims court. In case of suit, you agree the venue shall be in Collin County , Texas.

**Signed** _____ **Date** _____

(If patient is a minor, parent or guardian must sign.)

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowedgement*

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)



This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

# 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 **April 14, 2003**, 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 informa.tion that we maintain, including health information we creat-ed 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 ou·r Notice at any time. For more information about our privacy practices, or for addition-al 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 pro-viding 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 oper-ations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training progrnms, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare opera-tions, you may give us written authorization to use your health information or to disclose it to anyone for any pur-pose. 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 reason-able 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 communicati9ns 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 dis-close 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 intelli-gence, 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 circum-stances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voice-mail 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.** for each page, **$0** 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 infor-mation 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: I**f 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 1.isted 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: DONNA CARUSO Fax: 972-867-9321 Address: 5501 Independence Pkwy., Ste. 200, Plano, Texas 75023