Welcome To Our Office

Date _____

Patient Name _____ Birth Date _____

Address _____ City _____ Zip Code _____

Home Phone: _____ Cell Phone _____ Soc Sec # _____

Email Address: _____

EMPLOYMENT INFORMATION

Name of Employer _____ Phone # _____

DENTAL INSURANCE INFORMATION

Name of Ins. Co. _____ Insured's Employer _____

Name of Insured (if different from patient) _____ Insured's Date of Birth _____

Insured's Soc Sec # _____ Insured's Relationship to Patient _____

Group #/Group Name _____ Insured Retired? From What Company _____

SPOUSE, PARENT OR RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____ City/Zip Code _____

Employer _____ Phone # _____

DENTAL HISTORY

Do you see a dentist regularly? YES NO If yes, name of Dentist _____ How Long? ____

DENTAL CONDITION (CIRCLE YES OR NO)

HAVE YOU EVER:

Been told you have gum trouble.....Yes No

Have you had trench mouth/?.....Yes No

Been treated for periodontal disease..... Yes No

Had orthodontic treatment..... Yes No

DO YOU EVER:

Do you clench your teeth?.....Yes No

Do you have swollen gums?.....Yes No

Do you have bleeding gums?.....Yes No

Do you have tooth sensitivity?..... Yes No

Are you unhappy with the appearance of your teeth or smile?..... Yes No

Would you be disturbed if you lost your teeth?..... Yes No

FOR WOMEN ONLY

Are you pregnant? ..... Yes No If yes, what month_____Are you nursing..... Yes No

Are you taking birth control pills? ..... Yes No Have you been through menopause..... Yes No

Are you taking hormonal supplements? Yes No

MEDICAL CONDITION (CIRCLE YES OR NO)

DO YOU HAVE OR HAVE YOU EVER HAD:

Heart Failure..... Yes No

Heart Disease..... Yes No

Heart Attack..... Yes No

Congenital Heart Defect Yes No

Heart Murmur..... Yes No

High Blood Pressure. Yes No

Low Blood Pressure.. Yes No

Heart Pacemaker.....Yes No

Arteriosclerosis..... Yes No

Mitral Valve Prolapse. Yes No

Artificial Heart Valve.. Yes No

Heart Surgery..... Yes No

Congenital Heart Disease	Yes	No	Rheumatic Fever.....	Yes	No	Rheumatic Heart Disease	Yes	No
Stroke.....	Yes	No	Blood Thinners.....	Yes	No	Angina Pectoris.....	Yes	No
Arthritis.....	Yes	No	AIDS.....	Yes	No	Blood Transfusions.....	Yes	No
Rheumatism.....	Yes	No	HIV Positive.....	Yes	No	Hemophilia.....	Yes	No
Pain in Jaw Joints (TMJ)	Yes	No	Frequent Headache.....	Yes	No	Blood Disorder Anemia...	Yes	No
Ever Taken Cortisone....	Yes	No	Cold Sores/Fever Blisters....	Yes	No	Sickle Cell Disease.....	Yes	No
Artificial Joint.....	Yes	No	Do You Smoke.....	Yes	No	Bruise Easily.....	Yes	No
Kidney Disease.....	Yes	No	History of Smoking.....	Yes	No	Drug Addiction.....	Yes	No
Liver Disease.....	Yes	No	Drink Alcohol.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Yellow Jaundice.....	Yes	No	Phen-Fen Diet Medication.	Yes	No	Ever Fainted.....	Yes	No
Thyroid Disease.....	Yes	No	Emphysema.....	Yes	No	Dizzy Spells.....	Yes	No
Diabetes.....	Yes	No	Chronic Cough.....	Yes	No	Nervousness.....	Yes	No
Ulcers.....	Yes	No	Tuberculosis.....	Yes	No	Psychiatric Treatment....	Yes	No
Hiatal Hernia.....	Yes	No	Asthma.....	Yes	No	Osteopenia/Osteoporosis	Yes	No
Cancer.....	Yes	No	Hay Fever.....	Yes	No	Bisphosphonates Meds...	Yes	No
Radiation Therapy.....	Yes	No	Allergies or Hives.....	Yes	No	Chemotherapy.....	Yes	No
Sinus Trouble.....	Yes	No	Hepatitis A (infectious)...	Yes	No	Glaucoma.....	Yes	No
Cataracts	Yes	No	Hepatitis B (Serum).....	Yes	No	History of Surgery.....	Yes	No
Cosmetic Surgery.....	Yes	No	Hepatitis C.....	Yes	No			

Height: _____ Weight: _____

_____

_____

_____

HAVE YOU OR DO YOU:

Been under the care of a physician in the last year..... Yes No Reason: _____

Had a major illness..... Yes No Reason: _____

Take aspirin daily..... Yes No Reason: _____

Had abnormal bleeding tendencies ("Free Bleeder", Hemophilia or prolonged bleeding after extraction)..... Yes No

PLEASE LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING

Name _____ Reason _____ Dosage _____

Name _____ Reason _____ Dosage _____

Name _____ Reason _____ Dosage _____

Name _____ Reason _____ Dosage _____

Name _____ Reason _____ Dosage _____

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO MEDICATIONS..... Yes No

If yes, name of medication(s) _____

_____

PHARMACY YOU USE _____ ***PHONE NUMBER*** _____

NAME OF PHYSICIAN _____ ***PHONE NUMBER*** _____

DATE OF LAST PHYSICAL _____

CONSENT

The undersigned hereby authorizes the doctor or staff to take radiographs (x rays), study models, photographs, or any diagnostic aids deemed appropriate to make a thorough diagnosis. All responsibility of payment for Dental Services provided in this office for myself or my dependent is totally mine, due and payable at the time of services unless a previous financial arrangement has been made.

I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner. I will inform the doctor of any changes in my medical history and any changes in my medications.

Patients Signature _____ Date _____

(Guardian if patient is a minor)

Dentist Signature _____ Date _____

** PLEASE READ CAREFULLY **

We strive to accommodate our patients by providing quality dental care in a timely manner. To effectively do so, our office has implemented the following appointment policy:

Our staff will attempt to make confirmations via text message two days prior to your appointment and 1 day via phone call. If our staff leaves a message via voicemail or with someone other than the patient/guardian, it is the patient's responsibility to call our office to confirm or change their appointment.

**PLEASE KEEP IN MIND REMINDER CALLS ARE A COURTESEY ONLY! IF YOU DO NOT RECEIVE A CALL IT DOES NOT MEAN YOU DID NOT MAKE AN APOINTMENT. **

As a courtesy to our office, cancellations must be made 48 hours prior to your scheduled appointment. After first cancelled or no-show appointments, we WILL charge a $25.00 fee.

Late Arrivals: We realize there will be times when due to extraneous circumstances, you may be late for an appointment. In such cases it may be necessary to shorten the length of the service, change the procedures to be completed or reschedule for another date and time.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed Comal Hills Dental

Patient Name

Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____/ _____

Signature of Patient / Date

****

Comal Hills Dental was unable to obtain acknowledgement because:

Patient Refused - Reason_____

Other_____

_____

Comal Hills Dental

NOTICE OF PRIVACY PRACTICE

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 Comal Hills Dental Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. NOTE: If you pay out-of-pocket in full for the care or service provided, you have the right to ask us to restrict the disclosure of that information to your health plan.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Comal Hills Dental. For example, information on the services you received may be used to sup-port budgeting and financial reporting, and activities to evaluate and promote quality.

Individuals involved in you care or payment for your care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: When a research and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures that require your authorization: Disclosure of your health information or its use for any purpose other than those allowed or required by law requires your specific written authorization. Examples of these would be psychotherapy notes, marketing or fundraising activities. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders and testing results: Your health information will be used by our staff to send you appointment reminders. We may also contact you to provide results from exams or tests and to provide information that describes or recommends treatments for your care.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples are billing or copying services, etc. We may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- **The right to receive a printed copy of this notice**

- **The right to inspect and copy your protected health information**
  This means that you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper and electronic copies as established by professional, state or federal guidelines.

- **The right to request restrictions on the use and disclosure of your protected health information**
  This means you may ask us in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it , except in emergency circumstance when the information is needed for your treatment. In certain cases, we may deny your request for restriction. You have the right to request in writing, that we restrict communication to your health plan regarding a specific treatment or service that you or someone on your behalf, has paid in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

- **The right to receive request and alternative means of confidential communications concerning your medical condition and treatment**
  This means that you have the right to ask us to contact you about medical matters using an alternative method and to a alternative destination (i.e., cell phone number or alternative address, etc.) designated by you. You must inform us in writing, using the form provided by our practice. We will follow all reasonable requests.

- **The right to amend or submit corrections to your protected health information**
  This means that if you believe that the information in your health record is incorrect or that information is missing, you have the right to request that we correct the records. Your request must be in writing and include the reason you are requesting the change. In certain cases we may deny your request.

- **The right to receive an accounting of how and to whom your protected health information has been disclosed to entities or persons for reasons other than treatment, payment or healthcare operations**

- **The right to receive notification following a breach of unsecured protected health information**

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Privacy Officer at the address below. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact Person
If you would like to submit a comment, concern or complaint about our privacy practices, you can do so by sending a letter or contacting the Privacy Officer with your concerns to:

Privacy Officer
Comal Hills Dental
172 Creekside Park, Suite 102
Spring Branch, Texas 78070
830-438-2121

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Revised Effective Date : November 26, 2019

Financial Policy

Comal Hill Dental's mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimum care easy and manageable for our patients by offering several payment options. Our office accepts the following methods of payment:

- Check
- Credit card: Visa. Master Card. American Express and Discover
- Care Credit

Please note:

In order to reserve an appointment for treatment at Comal Hills Dental, total payment of patient portion is required. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received which may include laboratory fees incurred.

As a courtesy to patients with insurance. our office will work with your carrier to maximize your benefits and assist you with filing your insurance claim(s). Treatment estimate and coverage may be different if your deductible has not been met, if your insurance pays for alternate benefits. or if your insurance maximum has been met. Comal Hills Dental will not be held accountable for any discrepancies in your insurance claim. Any overpayment will be credited or refunded, and underpayment will be billed to patient. If our office does not receive payment from your insurance carrier within 120 days, patient will be responsible for payment of treatment fees to our office and collection of benefits directly from insurance carrier.

Comal Hills Dental charges a $30 fee for returned checks.

By signing this document you confirm that you have read and understand this financial policy.

_____ _____

Patient/ Guardian signature Date

COMAL HILLS Dental

HOW DID YOU HEAR ABOUT US?

Please circle all that apply:

Your Amazing Postcard

Your Amazing Website

My Amazing Family or Friend: _____

My Awesome Insurance

An Awesome Employee

Google

Yelp

Facebook

Next door