CRESTWATER DENTAL - 17125 Westheimer Rd, Houston, TX - (281) 741 -1000

Patient Information

Patient Name, Middle Name, Last Name			SS/HIC/Patient ID #	Today's Date
Address	City		State	Zip
Status ☐ Single ☐ Married ☐ Minor ☐ Other		Sex ☐ M ☐ F	Birthdate	Age
Home telephone no.	Work telephone no., ext.	Cellular phone	E-mail	
Employer/School name	Occupation		Emergency contact name, telephone no., relationship	
How did you hear about our office? ☐ Insurance ☐ Website ☐ Referral ☐ Drove by ☐ Other._____			If referral, whom may we thank for referring you?	

Dental Insurance

Insurance company		Subscriber's name	Birthdate	SS#
Member ID#	Group ID#	Employer	Relationship to patient	
If patient is covered by additional insurance, please fill out:				
Insurance company		Subscriber's name	Birthdate	SS#
Member ID#	Group ID#	Employer	Relationship to patient	

Dental History

Reason for today's visit	Former Dentist, city, state	Date of last dental visit	Date of last dental Cleaning

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Food collection between the teeth	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Loose teeth or broken filling	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No		
How often do you brush?	_____	How often do you floss?	_____		

Assignment of Benefits and Release of Information

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign
Name of Insurance company(ies)

directly to **Dr. Carol Chang** all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and the insurance payable amount is only an estimate of what the insurance may or may not pay for my treatment. I authorize the use of my signature on all insurance submissions.
The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment or services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative	Print name of Patient, Parent, Guardian or Personal Representative	Date	Relationship

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Health History

Physician's Name	Telephone no.	Date of last visit

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

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
		Psychiatric Care	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No If Yes, why? _____

Women:

Are you pregnant? ☐ Yes ☐ No	Due date	Are you nursing? ☐ Yes ☐ No
Taking birth control pills? ☐ Yes ☐ No	If yes, you should know that taking antibiotics may make your birth control pills ineffective. Initials_____	

Medications	Allergies
List any medications you are currently taking and why:	☐ Aspirin ☐ Local Anesthetic ☐ Barbiturates (Sleeping pills) ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Iodine ☐ Other _____ ☐ Latex _____
Pharmacy Name, telephone no.	

Acknowledgement of receipt of Privacy Practices Notice

I have received a copy of this office's Privacy Practices Notice.	Signature	Date

Dentist's Notes

_____

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**********PLEASE READ CAREFULLY AND SIGN BELOW**********

INSURANCE

Our office is pleased to accept your insurance. We will verify your insurance, file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between YOU and your INSURANCE COMPANY and not between the insurance company and the Dentist. Our office will make every attempt, at the beginning of your care, to receive verification of your policy and what it covers however; *we cannot guarantee that your insurance will pay. If for some reason, your claim is denied or not paid in full, you are responsible for the balance.*

PAYMENTS

You are required to pay your insurance deductible and any *estimated* percentages that are not covered by your insurance. We will bill your insurance as soon as care is rendered. Your insurance should pay within 30 days from the date filed. If for any reason your insurance does not pay, you will be responsible for the entire balance after 60 days from the date of service. All balances past 60 days will accrue a finance of 18% APR.

APPOINTMENTS GUIDELINES

Our office strives to maintain a daily schedule that runs smoothly and reduces patient wait time. When you schedule an appointment, we reserve that time for you and we feel that you should be seen on time. Missed appointments and patients that are consistently late are bad for our schedule. This is not considerate of our time or other patients that might have needed that appointment time. To help maintain the best possible schedule we count on you to keep your scheduled appointment. Therefore, we have the following policy:

If you do not give us 24 hours advanced notice to cancel, there is a $50 fee for each hour of time scheduled. In addition, any future appointments will require a deposit.

CHILDREN

A parent or guardian **must be present** during the appointment. We request that the parent/guardian stay in the waiting room unless otherwise requested by the dentist to be present in the treatment rooms.

I understand and acknowledge that I am financially responsible for all services provided for myself/or minor child. I agree that it is my responsibility to pay any remaining balance after insurance has paid. In case of default of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account. I also agree and understand the appointment guidelines.

PATIENT'S NAME (please print)_____

If child, please print name of responsible party_____

Signature _____Date_____

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 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 practically 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 $0.15 for each page, $8 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.