

Welcome To Our Office

Patient Information

Date_____

Name_____ Male_____ Female_____

Birthdate_____ Age_____ Social Sec. #_____ - _____ - _____

Address_____ City_____ State/Zip_____

___Minor ___Single ___Married ___Divorced ___Widowed ___Separated

Home Phone_____ Cell Phone_____ Pager_____

Drivers Lic.#_____ Email Address_____

Patient's or Parent's Employer_____ Work Phone_____

Occupation_____ Full Time_____ Part Time_____

Spouse or Parents Name_____

Employer_____ Work Phone_____

If Student, Name of School /College_____

Full Time_____ Part Time_____

Person to Contact in Case of Emergency_____ Phone_____

Whom May We Thank for Referring You: ___Phone Book ___Website
Friend / Coworker_____

Responsible Party (if someone other than applicant)

Name_____ Relationship to Patient_____

Address_____ City_____ State/Zip_____

Birthdate_____ Social Sec. # _____ - _____ - _____

Home Phone_____ Cell Phone_____

Pager_____ Drivers License # _____

Employer_____ Work Phone_____

Do You Have Dental Insurance? ___Yes ___No

Preferred Pharmacy_____ **Phone**_____

Preferred Hygienist_____

DENTAL HISTORY

Previous Dentist Name _____ **Phone** _____

Date of last dental visit _____ Last Dental Cleaning _____

Recent X-rays? ___ Full Mouth Series ___ Jaw Joints ___ MRI ___ CT Scan

How often do you have a dental examination and cleaning? _____

How often do you brush your teeth? _____ Floss? _____

What other dental aids do you use? (Sonicare, Braun, proxy brush, etc.) _____

Do you have active dental problems now? (Check all that apply)

- Toothache
- Bleeding Gums
- Decay
- Broken Teeth

Have you ever had:

- Orthodontic Treatment
- Oral Surgery or teeth extracted
- Periodontal (gum) Treatment
- Endodontic (root canal) Treatment
- Your teeth ground or bite adjusted
- Have you ever had general anesthesia
- Ever had a broken jaw
- Missing back teeth with no replacement
- Have you ever had surgery on joint? When _____ By Whom _____
- Have you ever had cortisone injected into joints? When _____ By Whom _____

Occlusal Habits

Do you:

- Clench or grind your teeth? ___ AM ___ PM
- Use a Bite Plate, Splint or Mouth Guard?
- Teeth hit in front first
- Cheek Biting
- Nail Biting
- Pencil / Pen Biting
- Tired jaws, especially in the morning
- Have jaws that pop or hurt
- Gum Chewing

Are any of you teeth sensitive to:

- Hot or Cold
- Biting or Chewing
- Sweets
- Mouth odor or bad tastes
- Cold sores, blisters or any other oral lesions
- Have you noticed any loose teeth or a change in your bite?
- Does food tend to get caught between your teeth? Where? _____
- Has a previous dentist had difficulty getting you numb?

DENTAL HISTORY

Is there anything you would change about you smile and/or teeth if you could? **Yes / No**

Have you had dental treatment recommended in the past and not followed through? **Yes / No**
If so, what are the reasons? (fear, money, etc....)

Have you ever experienced prolonged bleeding from a cut or a dental procedure such as an extraction or a cleaning? **Yes / No**

Have you ever been involved in an accident or injury (including sports injury, slips or falls, ski accidents, etc.) **Yes / No**

When? _____

What Happened? _____

Did the symptoms start after this accident? **Yes / No**

Explain: _____

Is the symptom(s) due to an illness, injury or work related accident? **Yes / No**

Place of the accident or injury: _____

Date and time of injury: _____

Explain: _____

MEDICAL HISTORY

Date of last completed medical examination? Month _____ Year _____

Are you currently under medical treatment? Yes / No

Explain: _____

Treating Physician _____

List any MEDICATIONS that you are currently taking:

Medication	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY

- Heart Surgery
- Heart Murmur
- Mitral Valve Prolapse
- Stroke
- High Blood Pressure
- Chest Pain
- Shortness of Breath
- Artificial Heart Valve
- Pacemaker
- Rheumatic Fever
- Arthritis / Rheumatism
- Swelling of Ankles
- Anemia
- Fainting / Dizziness
- Ulcer
- Diabetes
- Thyroid Disease
- Kidney Disease
- Hepatitis (What Type?) _____
- Liver Disease
- Glaucoma
- Contact Lens Wearer
- Artificial Joint (Replacement)
- Emphysema
- Tuberculosis
- Asthma
- Hay Fever or Allergies
- Sinus Trouble
- Tonsil or Adenoid Problems
- Tumor or Cancer (What Type?) _____
- Major Operations (Please List) _____

Are you allergic to or have had any reactions to the following:

- Local Anesthetics (Novocain)
- Sulfa Drugs
- Penicillin
- Barbiturates
- Sedatives
- Iodine
- Aspirin
- Codeine
- Latex
- Any Metals (nickel, mercury, etc.)
- Other (Please List)

MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY

- Significant Weight Change In The Last Year
- Fatigue
- Trouble Breathing While Sleeping
- Sexually Transmitted Disease
- HIV Positive
- AIDS
- Bruise Easily
- Epilepsy or Seizures
- Frequent Headaches.... How Often? _____
- Migraines.....How Often? _____
- Psychiatric/Psychological Care
- Depression or Anxiety
- Bipolar
- OCD
- ADD or ADHD
- Neurological Disorder
- Current or Past Problems with Alcohol or Drugs
- Smoke.....How much? _____
- Chew Tobacco.....How much? _____
- Diet Medically Supervised
- Snore
- Apnea
- Radiation Therapy
- Chemotherapy
- Blood Transfusion
- Hemophilia
- Sickle Cell Anemia

Do you take vitamin or mineral supplements? Herbal Supplements? If so, please list:

Please note any other pertinent information that has not been covered previously:

FOR WOMEN ONLY

- Are you or could you be pregnant? If so, what is your delivery date? _____
- Are you nursing?
- Are you taking oral contraceptives?
- Do you have a history of previous miscarriage
- Have you had a hysterectomy? Partial Complete
- Have you ever been diagnosed with PMS?
- Have you reached Menopause?
- Are you taking hormone replacements? If so, what? _____

MEDICAL HISTORY

AUTHORIZATION: I hereby authorize Dr. Guy Waldron and/or the staff of this dental office to administer such medications and to perform such diagnostic therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these medical and dental histories is correct to the best of my knowledge. I also authorize the doctor and/or staff to contact my healthcare giver(s) concerning my treatment if necessary.

In an effort to keep our fees affordable, we have adopted a no billing policy. **Payment is due at the time of service.** I authorize and request my insurance company to pay directly to the dentist or dental group the insurance benefits. I understand that my dental insurance may pay **LESS** than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and/or all my dependents. We accept cash, personal checks, debit cards, Visa, MasterCard and American Express. We also have a third party administrator that you may apply to for monthly payments.

Signature of Patient (or parent of minor) _____ Date _____

Doctors Comments:

Doctor's Signature

Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____
Address: _____
Telephone: _____ Email: _____
Social Security Number: _____

Section B: To the Patient. Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare options, of the uses and disclosures we may make of your protected health information, and of the other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office:

Telephone: 903-759-7196 **Fax:** 903-759-7197
Address: 3010 HG Mosley Parkway, Longview, TX 75605

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the number and address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

OVER PLEASE

Personal Representative's Name: _____
Relationship to Patient: _____

If diagnostic photographs are taken at you appointment, do we have permission to use them for continuing education, advertising and patient education? **YES / NO**

Signature: _____
Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Guy G. Waldron, Jr., D.D.S.
3010 H.G. Mosley Parkway
Longview, TX 75605
903-759-7196

BROKEN APPOINTMENT POLICY

Reserved appointment time that all patients in any dental office is limited and valuable.

It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion.

So that the dentist, our staff and other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment, (24 hours advance notification), will result in a \$50.00 fee being charged. That charge is in accordance with our dental office's broken appointment policy for all our patients, is to be paid prior to the scheduling of any new appointment. The patient is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff.

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 this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____ 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 the Notice and make the new Notices 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 providing treatment to you.

Payment: We may use and disclose your health information to obtain payment 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 disclosure 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 our 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 the 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 the 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 of 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 you 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, \$_____ 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: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

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Guy G. Waldron, Jr. D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY RECORDS

You May Refuse to Sign This Acknowledgment

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 our 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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