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**Patient: Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **M. Init.** \_\_\_\_\_

**If Minor Parent\Guardian:** \_\_\_\_\_

**Sex:**         **Male**         **Female**

**Marital Status:**  **Married**    **Divorced**    **Separated**    **Single**    **Widowed**

**DOB:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**Drivers License:** \_\_\_\_\_

**Employer & Occupation:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State/Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Emergency Contact #:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**How did you hear of our office:** \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Primary reason for dental appointment:    \_\_\_ Examination    \_\_\_ Emergency    \_\_\_ Consultation

**DENTAL HISTORY:**

Please Circle

- Do you have a specific dental problem? Describe: \_\_\_\_\_ YES    NO
- Do you have a dental examination on a routine basis? Last visit \_\_\_\_\_ YES    NO
- Do you think you have active decay or gum disease? \_\_\_\_\_ YES    NO
- Do you brush and floss on a routine basis? Explain \_\_\_\_\_ YES    NO
- Do your gums bleed? Explain \_\_\_\_\_ YES    NO
- Do you like your smile? Why? \_\_\_\_\_ YES    NO
- Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ YES    NO
- Do you ever have clicking, popping, or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ YES    NO
- Have your past experiences in a dental office always been positive? \_\_\_\_\_ YES    NO
- Do you smoke or chew? Any sores or growths in your mouth? Explain \_\_\_\_\_ YES    NO

**MEDICAL HISTORY:**

- Are you under a physician's care now? Why? \_\_\_\_\_ YES    NO
- Have you ever been hospitalized or had a major operation? Explain \_\_\_\_\_ YES    NO
- Have you ever had a serious injury to your head or neck? Explain \_\_\_\_\_ YES    NO
- Are you taking any medications, pills, or drugs? What? \_\_\_\_\_ YES    NO
- Are you on a special diet? Explain \_\_\_\_\_ YES    NO

Are you allergic to any of the following?

\_\_\_ Penicillin    \_\_\_ Latex    \_\_\_ Aspirin    \_\_\_ Codeine    \_\_\_ Acrylic    \_\_\_ Metal    \_\_\_ Local Anesthetic

Other? If yes, please explain: \_\_\_\_\_

Women (Please Check): \_\_\_ Pregnant / Trying to get pregnant    \_\_\_ Taking oral contraceptives    \_\_\_ Nursing

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

- |                                  |                              |                              |                                   |
|----------------------------------|------------------------------|------------------------------|-----------------------------------|
| YES/NO Alzheimers Disease        | YES/NO Cortisone Medicine    | YES/NO Hemophilia            | YES/NO Recent Weight Loss         |
| YES/NO Anaphylaxis               | YES/NO Diabetes              | YES/NO Hepatitis A           | YES/NO Renal Dialysis             |
| YES/NO Anemia                    | YES/NO Drug Addiction        | YES/NO Hepatitis B/C         | YES/NO Rheumatic Fever            |
| YES/NO Angina                    | YES/NO Easily Winded         | YES/NO Herpes                | YES/NO Rheumatism                 |
| YES/NO Arthritis/Gout            | YES/NO Emphysema             | YES/NO High Blood Press.     | YES/NO Scarlet Fever              |
| YES/NO Artificial Heart Valve    | YES/NO Epilepsy / Seizures   | YES/NO High Chol.            | YES/NO Shingles                   |
| YES/NO Artificial Joint(s)       | YES/NO Excessive Bleeding    | YES/NO Hives / Rash          | YES/NO Sickle Cell Disease        |
| YES/NO Asthma                    | YES/NO Excessive Thirst      | YES/NO Hypoglycemia          | YES/NO Sinus Trouble              |
| YES/NO Bacterial Endocarditis    | YES/NO Dizziness             | YES/NO Irr. Heartbeat        | YES/NO Spina Bifida               |
| YES/NO Blood Disease             | YES/NO Frequent Cough        | YES/NO Kidney Problems       | YES/NO Stomach/Intestinal Disease |
| YES/NO Blood Transfusion         | YES/NO Frequent Diarrhea     | YES/NO Leukemia              | YES/NO Stroke                     |
| YES/NO Breathing Problems        | YES/NO Frequent Headaches    | YES/NO Liver Disease         | YES/NO Swelling of Limbs          |
| YES/NO Bruise Easily             | YES/NO Genital Herpes        | YES/NO Mitral Valve Prolapse |                                   |
| YES/NO Cancer                    | YES/NO Glaucoma              | YES/NO Nervousness           | YES/NO Thyroid Disease            |
| YES/NO Chemotherapy              | YES/NO Hay Fever             | YES/NO Jaw Joint Pain        | YES/NO Tonsillitis                |
| YES/NO Chest Pains               | YES/NO Heart Attack/Failure  | YES/NO Psychiatr. Care       | YES/NO Tumors or Growths          |
| YES/NO Cold Sores                | YES/NO Heart Murmur          | YES/NO Premedication         | YES/NO Ulcers                     |
| YES/NO Congenital Heart Disorder | YES/NO Heart Pace Maker      | YES/NO Radiation Tmt.        | YES/NO Venereal Disease           |
| YES/NO Convulsions               | YES/NO Heart Trouble/Disease | YES/NO Tattoos/Piercings     | YES/NO Yellow Jaundice            |

Have you ever had any serious illness not listed above? Explain: \_\_\_\_\_ YES / NO

Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ YES / NO

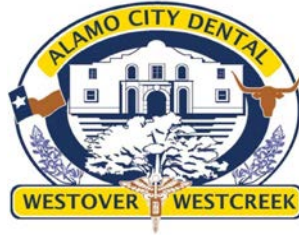
To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

**X** \_\_\_\_\_  
PATIENT SIGNATURE (PARENT OR GUARDIAN)

DATE: \_\_\_\_\_

Reviewed By Doctor: \_\_\_\_\_

DATE: \_\_\_\_\_ B/P \_\_\_\_\_ P \_\_\_\_\_



Alamo City Dental, P.C.  
9594 Potranco Road Suite 101  
San Antonio, TX 78251  
Phone: (210) 523-2323  
Fax: (210) 314-1438

**Please Provide Current Medication List**

If you require antibiotic premeditations prior to dental treatment, please obtain prescription from your physician or our office.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_

Effective date of notice:  
**NOTICE OF PRIVACY PRACTICES**

Alamo City Dental, PC  
9594 Potranco Rd. Suite 101,  
San Antonio, TX 78251  
Phone: (210) 523-2323  
Fax: (210) 314-1438

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU  
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO  
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations: Acquiring Dental/Medical Records.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;

- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- Other:

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your

statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

#### **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

#### **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

#### **FOR MORE INFORMATION**

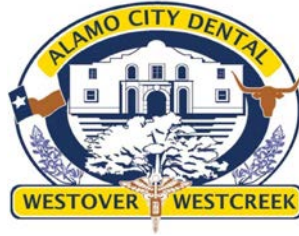
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

#### **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Alamo City Dental's Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Alamo City Dental Office Policies

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact people have different needs in fulfilling their financial obligations, we are providing the following payment options: **Payment is due at the time of service**

### Payment Policy:

- *Cash, Check, Visa, and MasterCard* are accepted.
- A 5% pre-payment courtesy credit will be offered for services over \$1000.00 that are paid in full, cash or check, prior to the initial treatment appointment.
- *Flexible Payment Options:* If extensive treatment is required and you wish to extend your payments, we can arrange low monthly payments with approved credit.

### Insurance Policy:

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage. Because your insurance policy is an agreement between you and the insurance company, we ask that all patients be directly responsible for all charges. If your insurance company does not pay their estimated benefits within 30 days from the date of service, you are responsible for the entire treatment fee. Balance over 60 days will incur a finance charge of 18% APR.

### Cancellation Policy:

Our goal is to provide you with quality dental care and personal attention. Your appointment time is reserved *just for you*. If you cannot keep your appointment, please provide at least 48 hours of notice. If you are an established patient and you fail your appointment we reserve the right to charge \$50.00 per half hour.

### Informed Consent for X-rays & Photographs:

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give permission for such items to be used for purposes of research, education, marketing and publication in professional journals.

### Release of Dental Records Policy:

To insurance company (if applicable)

I authorize Alamo City Dental to release my dental records to my insurance company upon request, including, but not limited to, periodontal charting, radiographs, and diagnostic photos.

### Returned Check Policy:

A \$30.00 fee will be assessed for all returned checks.

### Acknowledgement:

I hereby acknowledge and agree to the above office policies. I also have received a copy of the Notice of Privacy Practices of this office. Please note: it is your right to refuse to sign the acknowledgement.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
ACD