

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Any Metals (e.g. nickel, mercury, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other (please list) _____		
			12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?...	<input type="checkbox"/>	<input type="checkbox"/>
			13. Women Only:		
			a) Are you pregnant or think you may be pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>
			b) Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
			c) Are you taking oral contraceptives?.....	<input type="checkbox"/>	<input type="checkbox"/>

High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	Angina.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting / Seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss.....	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant.....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection.....	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	Other.....	<input type="checkbox"/>	<input type="checkbox"/>

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?.....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?..... If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?.....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____
Signature of patient (or parent/guardian if minor)

Doctor's Comments _____
Signature _____ Date _____

JOHN MARK WEAVER, DDS PC
GENERAL DENTISTRY
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FELLOW OF ACADEMY OF GENERAL DENTISTRY
2000 NORTH GRANDVIEW
ODESSA, TEXAS 79761

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Fax (432) 362-0690

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services are due at the time services are rendered unless payment arrangements have been approved in advance by our office manager. We accept **cash, checks, MasterCard, Visa, Discover or Care Credit**. Returned checks will be subject to additional collection fees.

We file insurance claims as a **COURTSEY** to our patients. Your insurance is a contract between you, your employer and the insurance company.

Our fees are generally considered to fall within the acceptable range by most companies. Our fees are considered usual, customary and reasonable by most companies. Not all services are a covered benefit.

After **45 days**, if no response from insurance company for payment is received, you are responsible for payment of balance.

I have read the financial policy and agree with the terms.

x

Signature

Date

If you have any questions, please do not hesitate to ask us.

Thank you,

Kerri Cordova, Office Manager
Dr John Mark Weaver DDS

JOHN MARK WEAVER, DDS PC
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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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 31st, 2020 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To

request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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 Service.

Our Privacy Official: Kerri Cordova

Telephone: (432)362-2202 Fax: (432)362-0690

2000 N Grandview Ave Odessa, TX 79761

JOHN MARK WEAVER, DDS PC
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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby authorize John Mark Weaver DDS PC, to release healthcare information on my behalf to the following person(s) listed below:

Name: _____ DOB: _____

Address: _____

Phone: _____ Relationship: _____

I, _____ (patient or guardian's name) have received a copy of Notice of Privacy Practices for JOHN MARK WEAVER, DDS PC

X _____
Patient or Guardian 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 (please select from options below):

- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____