Medical Alert:

PATIENT
(PLEASE PRINT) Mr./Mrs./Ms. (Circle one)

REASON FOR TODAYS VISIT:

Male _____ Female _____

PATIENT NAME: FIRST _____ MI _____ LAST _____ DOB _____ _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ _____

CELL PHONE _____ WORK PHONE _____ HOME PHONE _____ SSN# _____ _____

E-MAIL _____ EMPLOYER _____

NAME OF PHYSICIAN & PHONE NO _____ DATE OF LAST PHYSICAL _____

IN CASE OF EMERGENCY CONTACT _____ PHONE _____

DO YOU HAVE A HISTORY OF:

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| A.I.D.S/HIV Positive | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Stroke | ☐ | ☐ |
| Alcoholism | ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Malignancies | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Allergies | ☐ | ☐ | Hearing Impaired | ☐ | ☐ | Neck & Back Problems | ☐ | ☐ | Ulcers | ☐ | ☐ |
| Anemia | ☐ | ☐ | Heart Disease | ☐ | ☐ | Nervous Problems | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Heart Valve, Murmur | ☐ | ☐ | Pacemaker | ☐ | ☐ | Bone Disease | ☐ | ☐ |
| Asthma | ☐ | ☐ | Hepatitis/Liver | ☐ | ☐ | Prosthetic Joints | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Cancer | ☐ | ☐ | Disease Hepatitis | ☐ | ☐ | Psychiatric Care | ☐ | ☐ | Thyroid Disease | ☐ | ☐ |
| Chemical Dependency | ☐ | ☐ | Carrier | ☐ | ☐ | Radiation Treatments | ☐ | ☐ | | | |
| Chest Pain | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | Are there any problem | | |
| Circulatory Problems | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | not listed you would like | | |
| Convulsions/Seizures | ☐ | ☐ | Kidney Dialysis | ☐ | ☐ | Scarlet Fever | ☐ | ☐ | to discuse? | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Latex Sensitivity | ☐ | ☐ | | | | | | |

List any medications you are taking including non-prescription drugs.

1 _____
2 _____
3 _____
4 _____

Are you allergic to any medications?

1 _____
2 _____
3 _____
4 _____

## DENTAL INFORMATION

1. Date of last dental visit: _____
2. If wearing dentures, age of dentures:_____ _____

| | YES | NO |
|---|---|---|
| 3. Do your gums bleed when brushing or eating? | ☐ | ☐ |
| 4. Do you ever clench or grind your teeth? | ☐ | ☐ |
| 5. Are your teeth sensitive to hot, cold or pressure? | ☐ | ☐ |

| WOMEN | YES | NO |
|---|---|---|
| Is there a possibility of pregnancy? | ☐ | ☐ |
| Estimated delivery _____/____/_____ | | |
| Are you nursing? | ☐ | ☐ |
| Are you taking birth control pills? | ☐ | ☐ |

*WOMEN NOTE:* Antibiolics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynocologist FOR asistance regarding additional methods of birth control.

On a scale of 1 to 10 with 10 being the highest rating:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

| I could change my smile I would make my teeth: | YES | NO |
|---|---|---|
| Whiter | ☐ | ☐ |
| Straighter | ☐ | ☐ |
| Close space | ☐ | ☐ |
| Replace black mercury fillings with tooth color restorations | ☐ | ☐ |
| Repair chipped teeth | ☐ | ☐ |
| Replace missing teeth | ☐ | ☐ |
| Less gum showing | ☐ | ☐ |
| Replace old crowns 0r caps that don't match | ☐ | ☐ |
| Do you prefer to save your teeth? | ☐ | ☐ |

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satis
I will not hold my dentist or any other member of his/her staff responsible for any errors that I have made in the completion of t

Signature of Patient (parent or guardian if minor): _____ Date: _____

Health History Reviewed by: _____ Dentist Signature: _____

# TMJ HEALTH QUESTIONNAIRE

Date: _____

CHIEF CONCERN _____

DATE OF ONSET _____

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **PAIN SYMPTOMS** | | | | | |
| Do you get headaches? | ☐ | ☐ | Do you get headaches in the right or left temple areas? | ☐ | ☐ |
| Do you get migraine headaches? | ☐ | ☐ | Do you get headaches in the front or back of your head? | ☐ | ☐ |
| Do you frequently have neck aches or stiff neck mussels? | ☐ | ☐ | Do you clench your teeth during the day? | ☐ | ☐ |
| Have you ever had chronic shoulder or back pain? | ☐ | ☐ | Do you clench your teeth at night? | ☐ | ☐ |
| Do you have trouble sleeping soundly? | ☐ | ☐ | Do you grind your teeth when asleep? | ☐ | ☐ |
| Are your jaws tired when you awaken? | ☐ | ☐ | When are your pain symptoms the worst? | ☐ | ☐ |
| Are your teeth sore when you awaken? | ☐ | ☐ | _____ | | |
| | | | Does anything make you feel better? | | |
| Have your wisdom teeth been extracted? | ☐ | ☐ | _____ | | |
| What medications, if any, are you taking? | | | How often do you take medication for relief of pain? | | |
| _____ | | | _____ | | |
| **TRAUMA OR ACCIDENTS** | | | Have you ever been involved in any serious accidents, | | |
| Have you ever had a severe blow to the head or jaw? | ☐ | ☐ | such as a car accident? | ☐ | ☐ |
| Any whiplash neck injures? | ☐ | ☐ | Details | | |
| | | | _____ | | |
| **JAW JOINT SYMPTOMS** | | | | | |
| Does your jaw feel tired after a big meal? | ☐ | ☐ | Do you feel or hear a 'clicking', 'popping 'or | | |
| Are there any foods you avoid eating? | ☐ | ☐ | cracking' noise from either jaw join? | ☐ | ☐ |
| Do you ever get dizzy? | ☐ | ☐ | Has your Jaw ever locked when you were | | |
| Do you ever feel faint? | ☐ | ☐ | unable to open or close? | ☐ | ☐ |
| Do you ever feel nauseated? | ☐ | ☐ | Do you have difficulty opening wide or yawning? | ☐ | ☐ |
| Is there a family history of jaw joint | | | Have you ever had pain in either jaw joint? | ☐ | ☐ |
| (TMJ) problems or headaches? | ☐ | ☐ | Does your jaw ache when you open wide? | ☐ | ☐ |
| **EAR AND EYE SYMPTOMS** | | | | | |
| Do you have pain in either ear | ☐ | ☐ | Do you wear glasses or contacts? | ☐ | ☐ |
| Do you suffer from any loss of hearing? | ☐ | ☐ | Are there times when your eyesight burs? | ☐ | ☐ |
| Do you have itchiness or stuffiness | | | Do you get pain in, around or behind either eye? | ☐ | ☐ |
| in either ear? | ☐ | ☐ | | | |
| Do you hear ringing, buzzing, or | | | | | |
| hissing sounds in either ear? | ☐ | ☐ | | | |
| **BREATHING** | | | | | |
| Do you have allergies? | ☐ | ☐ | Is your nose stuffed when you don't have a cold? | ☐ | ☐ |
| Do you have sinus problems? | ☐ | ☐ | Have you been diagnosed with Sleep Apnea? | ☐ | ☐ |
| Do you snore at night? | ☐ | ☐ | Have you had a sleep study done at a | | |
| | | | Sleep Clinic (hospital)? | ☐ | ☐ |

# ACCOUNT INFORMATION

## PLEASE PRINT AND COMPLETE ALL ENTRIES

| Guarantor's Name | Date of Birth | Martial Status<br>S M D W | Today's Date |
|---|---|---|---|
| | | | |

| Address (Street) (City) (State) | Home Phone | Cell Phone |
|---|---|---|
| | | |

| Name of Employer | Occupation | Work Phone ( Ext. ) |
|---|---|---|
| | | |

| Employer Address (Street) (City) (State) (Zip) | Social Security No. |
|---|---|
| | |

| Spouse's Name (Last - First - Middle) | Date of Birth | Name of Employer |
|---|---|---|
| | | |

| Dependent(s) Name (Last - First - Middle) | Date of Birth | Social Security No. | Home Phone |
|---|---|---|---|
| Name: _____ | _____ | _____ | _____ |
| Name: _____ | _____ | _____ | _____ |
| Name: | | | |

| Dependent(s) Address (if different) (Street) (City) (State) (Zip) |
|---|
| |

| Whom May We Thank for Referring You to Us? | E-Mail Address (For Appointment Confirmation & Specials in |
|---|---|
| | |

## INSURANCE INFOMATION

| Primary Inurance Name (Street) (City) (State) (Zip) |
|---|
| |

| Name of Insured | Relationship | I.D. No. | Group No. |
|---|---|---|---|
| | | | |

| Secondary Inurance Name (Street) (City) (State) (Zip) |
|---|
| |

| Name of Insured | Relationship | I.D. No. | Group No. |
|---|---|---|---|
| | | | |

I authorize and request my insurance company to pay directly to the dentist or dental group,insurance benefit otherwise payable to me. I understand that my dental insurance carrier may pay less than the amount due for services, I hereby agree to pay in full any amounts that are not paid by my insurance carrier within 90 days after services are rendered on my behalf or my dependents.

_____ _____

Signature Date

# FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

The person financially responsible for the patients' account must complete the Account Information before the patient sees the doctor.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

We accept:

- Cash
- Checks
- Credit Cards
  Ultimate Dental Care Office Accept: Visa, MasterCard or Discover.

**REGARDING INSURANCE:**

- We require deductible and copays to be paid at the time of service. Your insurance policy is a contract between you and your insurance company. However, we will automatically bill your insurance company for services rendered as a courtesy to you.
- If your insurance company has not paid the total claim within 10 days from the date of your treatment, the balance will automatically be billed to you. Please be aware that we may receive only partial amount of what was totally billed to your insurance company. You will be responsible for amounts the insurance company has determined as ineligible or not covered in full.
- If we cannot verify eligibility prior to treatment, you are expected to pay in full at the time of service. We will be glad to submit your insurance form and direct your insurance company to make payment directly to you.

**USUAL AND CUSTOMARY RATES:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usualand customary rates.

**MINOR PATIENTS:**

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or payment by cash or check at time of service has been verified.

**MISSED APPOINTMENTS:**

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00. Please help us serue you better by keeping scheduled appoiniments.

**LATE FEES:**

If your payment is not received on or prior to the due date on your statement, a late fee of $2S.00 will be added to your account. (For orthodontic patients, late fees are printed directly on your coupon payment books.)

Thank you lor understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the Financial Policy.

_____ _____

Signature of responsible Party Date

# Ultimate Dental Care Notice of Privacy Practices

**(Ultimate Dental Care herein referred to as UDC)**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT 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 your health information, to follow the terms of this Notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this Notice.

**How UDC May Use or Disclose Your Health Information**

UDC protects the privacy of your health information. The law permits UDC to use or disclose your health information for the following purposes:

**Treatment, Payment, and Regular Health Care Operations* - Information obtained by UDC will be used to provide services to you, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon request.

**As and When Required by law* -We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.), Judicial and Administrative, Deceased Person Information, Worker Compensations programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of armed forces when requested, or if you become an inmate in a correctional facility.

**Personal Communications* - We may contact you to provide appointment reminders, annual dental examination cards, and other information about treatment altematives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved with your care or payment for your care.

**Disclosure of Business Associates* -There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.

**Victims of Abuse, Neglect, or Domestic Violence* - We may disclose your health information to a govemment authority, such as a social service or protective services agencies, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

***Marketing Communicalions***. We must obtain your wriften authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or altemative treatments, or provideis without authorization.

**When UDC May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, UDC will not use or disclose your health information without your written autlrorization. If you do authorize UDC to use or disclose your health information for another purpose, you may revoke your authorization in writing at anytime- If the law provides additional restrictions upon any of the fore going uses and disclosures, we must follow the state law.

**You have the following rights with respect to your health informrtion.**

*You have the right to request restrictions on certain uses and disclosures ofyour health information. To make such a request, you must complete the **Restriction of the Use of Patient information form**. UDC is not required to agree to the restriction that you requested.

*You have the right to inspect and copy your health information as long as UDC maintains the health information. Your health information usually will include prescription and billing records. To inspect pr copy your health information, you must complete a **Request to Inspect Medical Records form** and submit the request to UDC. We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect or copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.

*You have the right to request that UDC amend your health information that is inconect or incomplete. To request an amendment, you must complete a **Request to Amend Medical Records**. UDC is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.

*You have the right to receive an accounting of disclosures of your health information we have made after April 14,2003 for most purposes other than treatment, payment, health care operations, information provided to you, and certain govemment functions. To request an accounting, you must complete a **Request for Accounting of Disclosure** to the location providing services. You must speciry the time period but may not be longer than six years. We will notify you ofthe cost involved and you may choose to withdraw or modify your request at that trme.

*You may request communication of your health information by altemative means or at altemative locations. For example, you may request that we contact you about medical matters only in writing or at a different residence or post oflice box. To request confidential communication of your health information, you must complete a **Request for Alternative Communication** to UDC. Your request must state how or when you would like to be contracted. We will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, contact us at Ultimate Dental Care, 910 W. Parker Rd., Suite 370, Plano, TX 75075.

**Chanses to this Notice of Privacy Practices**

UDC reserves the right to amend our practice and this Notice of Privacy Practices at any time in the future and to make the new Notice effective for all medical information we maintain. Until such amendment is made, UDC is required by law to comply with this Notice. The revised notice will be posted in the office and a paper copy will be available upon request.

**For More Information or to Report a Problem**

If you have questions or would like additional information about UDC privacy practices, you may contact Dental HIPAA Coordinator, at the address above. If you believe your privacy rights have been violated,you may file a written complaint, for which there will be no retaliation, using our form with HIPAA Privacy, or with the Secretary of Health and Human Services

**By Signing Below, I acknowledge that I hgve received the LIDC Privacy Notice**

_____ _____

Signarure of Patient or Authorized Representative Date