

PERRY
DENTISTRY

Mr. Mrs. Miss Ms. Dr. _____
Last First Middle Initial

Home/Cell Phone: _____

Email: (Used to confirm appointments only) _____

Address _____ Apt. no. _____

City, State, Zip _____

DOB: _____ Social Security # _____ - _____ - _____

Name of Spouse/Partner/Parent _____

Emergency Contact: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION

Name of Insured _____

Relationship to Patient _____

Insured's DOB _____

Soc. Sec. # _____ - _____ - _____

Insurance ID # _____

Employer _____

Insurance Co. _____

Insurance Phone Number: _____

Group # _____

Group Name _____

___ I am not covered by any Dental Insurance at this time

I hereby authorize Dr. Svetlana Perry, DDS, or her staff to release any and all medical and dental information pertinent to my treatment to the above-named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Svetlana Perry, DDS of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Dental Association, and that it is the sole power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. **I understand that I am ultimately responsible for the total costs of my treatment provided by Svetlana Perry, DDS.**

Privacy of Information Policy: I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Cancellation Policy: **There will be a substantial charge if a surgical treatment appointment is canceled with less than 24 hours.** Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner. **Payment: There is a 5% discount for full payment by cash, not including insurance reimbursement, at the time services are rendered.** We request that all balances be paid in full within 90 days of treatment, unless specific financial arrangements are made before treatment. I acknowledge that I have read and understand the above statements and policies and that this authorization remains valid and effective from the date of signing until revoked in writing.

Signature of Patient or Patient's Legal Guardian

Date of Signature

DENTAL QUESTIONNAIRE FOR NEW PATIENT

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS?

LESS THAN ONCE A YEAR ONCE A YEAR TWICE A YEAR THREE TIMES A YEAR FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM MO/YEAR OF YOUR LAST DENTAL X-RAYS

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH (CIRCLE ONE)?

VERY SATISFIED SATISFIED IT'S O.K. SOMEWHAT DISSATISFIED VERY DISSATISFIED

Yes No

DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?

ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?

IF YES, PLEASE DESCRIBE:

ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS FOR INFECTION? IF SO, PLEASE LIST:

DO YOUR GUMS EVER BLEED? IF SO, WHEN:

DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?

ARE YOU INTERESTED IN REPLACING LOST TEETH?

DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?

ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?

ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?

ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL? WHEN?

ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?

ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? WITH BRACES WITH REMOVABLE APPLIANCES

WHEN DID YOU GO THROUGH ORTHODONTIC CARE?

HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT?

SCALING/ROOT PLANING GUM SURGERY

WHEN DID YOU GO THROUGH PERIODONTAL CARE?

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR MAKES DENTAL TREATMENT EASIER FOR YOU:

I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA

I APPRECIATE THE USE OF LOCAL ANESTHETIC – IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL

I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL

I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)

I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT

I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE

I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR

I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM

I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY)

Signature of patient or legal guardian

Date

Reviewed by

HEALTH QUESTIONNAIRE FOR NEW PATIENT

YES NO

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?

IF YES, PLEASE DESCRIBE _____

HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?

IF YES, PLEASE DESCRIBE _____

ARE YOU TAKING ANY OVER THE COUNTER OR PRESCRIPTION MEDICATIONS AT THIS TIME?

IF YES, PLEASE LIST: _____

HAVE YOU EVER RECEIVED I.V., OR TAKEN ORALLY: ARETIA, ZOMETA, FOSAMAX OR ANY OTHER BIPHOSPHONATES?

HAVE YOU EVER TAKEN PONDIMIN (FENDLURAMINE), PHEN-FEN (PHENTERMINE) OR REDUX (DEXPHENFLURAMINE) FOR WEIGHT REDUCTION?

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL TREATMENT DUE TO ARTIFICIAL JOINTS OR HEART?

ARE YOU ALLERGIC TO ANY MEDICATIONS OR LATEX?

IF YES, PLEASE LIST _____

HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS AND OR ANESETHETICS?

IF YES, PLEASE LIST _____

HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?

HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?

IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?

ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND?

DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: PER DAY, WEEK, MONTH

DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: PER DAY, WEEK, MONTH

DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

SHORTNESS OF BREATH

HIGH BLOOD PRESSURE

LOW BLOOD PRESSURE

HEART VALVE PROSTHESIS

MITRAL VALVE PROLAPSE

CONGENITAL HEART LESION

RHEUMATIC FEVER

HEART MURMUR

DAMAGED HEART VALVE

HEART ARRHYTHMIA

TACHYCARDIA

HEART SURGERY

CARDIAC PACEMAKER

HEPATITIS OR JAUNDICE

RECEIVED BLOOD TRANSFUSION

IMPAIRED LIVER FUNCTION

KIDNEY DISEASE

IMPAIRED KIDNEY FUNCTION

ESOPHYGEAL REFLUX

HIATAL HERNIA

G.I. ULCERS

ANOREXIA OR BULEMIA

IRRITABLE BOWEL SYNDROME

COLITIS

DIABETES

RADIATION THERAPY

CHEMOTHERAPY

HISTORY OF CANCER

SLEEP APNEA

ASTHMA

BRONCHITIS

EMPHYSEMA

SINUS TROUBLES

PERSISTENT COUGH

TUBERCULOSIS

JOINT REPLACEMENT SURGERY

ARTHRITIS

CONNECTIVE TISSUE DISORDER

OSTEOPOROSIS

NEUROLOGICAL DISORDERS

STROKE

HEADACHES

MIGRAINES

EPILEPSY

SEIZURES

MENTAL HEALTH PROBLEMS

GLAUCOMA

WEAR CONTACT LENSES

SEVERELY IMPAIRED VISION

RECURRENT INFECTIONS

CHRONIC FATIGUE

RECENT WEIGHT LOSS

Perry Dentistry
6150 Eldorado Parkway Ste. 150
McKinney, Texas 75070

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 June 1, 2005 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 make the changes. Before we make a significant change in our privacy practices, we will change this Notice and the new Notice available upon request. You may request a copy of our Notice at any time.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operation. 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 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 when 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 or allowed under the Law.

To Your Friends and Family: 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 the other person to the extent necessary to help with your healthcare or with payment of 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 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 reasonable 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 official's health information required for lawful intelligence, counterintelligence, and other nation security activities. We may disclose to a 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 a portion of 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 obtain 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 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 .10 for each page, \$18.00 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 associated 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 12mth 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 of 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 make 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 may also submit a written complaint to the US 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 complaining with us or with the US Department of Health and Human Services.

If you have any questions, please contact Dr. Svetlana Perry, DDS. at 972.540.7500.

Notice of Privacy Practices Acknowledgement

Signature

Print Name

Date

I acknowledge I have received or have been given an opportunity to receive **Perry Dentistry** Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the **Perry Dentistry** Notice of Privacy Practices.

HIPPA RIGHT OF ACCESS FORM FOR A FAMILY MEMBER/FRIEND

I, _____ direct Perry Dentistry to disclose and release to the following people

Name and relationship of the person we are releasing information to:

Please check off the information you want released

- All and any information Appointment information
- Dental/Health Records
- Pending treatment

Name and relationship of the person we are releasing information to:

Please check off the information you want released

- All and any information Appointment information
- Dental/Health Records
- Pending treatment

Name and relationship of the person we are releasing information to:

Please check off the information you want released

- All and any information Appointment information
- Dental/Health Records
- Pending treatment

Patient Signature

Date

Appointments and Cancellations

When we make your appointment, we are reserving a room for your dental needs. We ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge of \$75.00 for not showing up for scheduled appointments.
Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is very valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit.

Patient Signature: _____ **Date:** _____