Bell Blvd Family Dental

Abram Tanner, DDs - Michael J. Farst, DDS

PATIENT INFORMATION *(Please Print Clearly)*

Name of Patient _____ SS# _____

Address _____Apt. #_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Other_____

Date of Birth _____ Age _____ Sex _____ Race _____ Marital Status _____

E-Mail Address _____ Employer _____ Position _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Check all that apply:

_____Google Search _____ Facebook _____ Yelp _____ Website _____ Doctor/Insurance _____ Office location

_____Friend/Existing Patient (Name:_____) _____Other_____
(Please Specify)

Parent or Responsible Party (if patient is under age 18)

Mother/Guardian's Name _____

Date of Birth _____Marital Status_____

Social Security No. _____

Address _____ Apt. # _____

City _____State _____ Zip _____

Home No. _____Cell No. _____

Employer _____ Work No. _____

E-Mail Address _____

Will the above party be responsible for any balance on the account? YES NO (circle one)

Father/Guardian's Name _____

Date of Birth _____ Marital Status_____

Social Security No. _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home No. _____Cell No. _____

Employer _____ Work No. _____

E-Mail Address _____

Will the above party be responsible for any balance on the account? YES NO (circle one)

Emergency Contact: _____ Phone No. _____

Relationship to Patient? _____

If the patient is covered by any dental insurance, please fill out the following:

Insurance Name _____ Insurance Phone No. _____
Employer _____ Phone No. _____ Group No. _____
Subscriber's Name _____ Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____ Relationship to Patient _____
Rank (If Military) _____ Military Branch _____
Sponsor's Unit (If Military) _____ Unit Phone Number _____

If the patient is covered by a second insurance, please fill out the following:

Insurance Name _____ Insurance Phone No. _____
Employer _____ Phone No. _____ Group No. _____
Subscriber's Name _____ Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____ Relationship to Patient _____
Rank (If Military) _____ Military Branch _____
Sponsor's Unit (If Military) _____ Unit Phone Number _____

CONSENT FOR SERVICES

I understand that forms for insurance claims will be submitted as long as I provide all the information necessary to complete filing. I authorize release of any information concerning the health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist. Staff will calculate ESTIMATED deductible and co-pay. Payment of this amount are due the day services are rendered. I understand that I am responsible for all costs of dental treatment within 30 days.

Patient or Legal Guardian's Signature: _____ Date: _____

HEALTH HISTORY FORM

As required by law (HIPAA), our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name _____ Height _____ Weight _____ Date of Birth ____/____/_____ Sex ☐M ☐F
Last First Middle

Reason for today's visit?_____

Medical Information

ALLERGIES

Are you allergic to or have you had a reaction to any of the following? To all "Yes" responses specify type of reaction.

☐ Latex ☐ Local anesthetics ☐ Aspirin ☐ Penicillin ☐ Codeine or other narcotics

☐ Metals ☐ Sulfa Drugs ☐ Foods ☐ Hay fever/seasonal ☐ Barbiturates, sedatives, or sleeping pills

☐ Any other allergies _____ ☐ No Known Allergies

If yes to any, please explain reaction: _____

WOMEN ONLY

Yes	No	Don't Know	
☐	☐	☐	Are you pregnant? If yes, how many weeks? _____ Due Date: _____
☐	☐	☐	Taking birth control pills or hormonal replacement? _____ Nursing? _____

CONGENITAL HEART DISEASE / ARTIFICIAL JOINTS

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Artificial (prosthetic) heart valve	☐	☐	☐	Congenital heart disease (CHD)
☐	☐	☐	Previous infective endocarditis	☐	☐	☐	Unrepaired, cyanotic CHD
☐	☐	☐	Damaged valves in transplanted heart	☐	☐	☐	Repaired (completely) in last 6 months
				☐	☐	☐	Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

☐ ☐ ☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____

☐ ☐ ☐ Have you had any complications or difficulties with your prosthetic joint? If yes, specify _____

☐ ☐ ☐ **Has a physician or other dentist recommended you take antibiotics prior to dental treatment?**

Yes	No	Don't Know	
☐	☐	☐	Are you taking or have taken oral bisphosphonates? (Fosamax, Actonel, Boniva) or I.V. Bisphosphonates? (Actonel or Aredia) If so, for how long? _____
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____
			_____ Date last seen by this physician _____
			Physician(s) _____ Name Phone Address City/State/Zip
☐	☐	☐	Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking? Prescribed _____
			Over the Counter/Herbal remedies _____
☐	☐	☐	Do you use tobacco (smoking, snuff)? If so, how interested are you in stopping? (Check one) ☐Very ☐Somewhat ☐Not Interested

Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding
☐	☐	☐	AIDS or HIV infection
☐	☐	☐	Anemia
☐	☐	☐	Hemophilia
☐	☐	☐	Arthritis
☐	☐	☐	Rheumatoid arthritis
☐	☐	☐	Systemic lupus erythematosus
☐	☐	☐	Autoimmune disease
☐	☐	☐	Cancer / chemotherapy / radiation treatment
☐	☐	☐	Cardiovascular disease

If yes, specify below:
- ❍ Angina
- ❍ Arteriosclerosis
- ❍ Congestive Heart Failure
- ❍ Damaged heart valves
- ❍ Heart attack Date: _____
- ❍ Heart murmur
- ❍ High blood pressure
- ❍ Low Blood Pressure
- ❍ Mitral valve prolapse
- ❍ Pacemaker
- ❍ Rheumatic Fever
- ❍ Rheumatic heart disease
- ❍ Stroke Date: _____

Yes	No	Don't Know	
☐	☐	☐	Chronic pain
☐	☐	☐	Chest pain upon exertion
☐	☐	☐	Eating disorder

If yes, specify _____

☐	☐	☐	Gastric reflux
☐	☐	☐	Gastrointestinal disease
☐	☐	☐	Ulcers
☐	☐	☐	Diabetes. If yes, specify:

- ❍ Type I (Insulin dependent)
- ❍ Type II

☐	☐	☐	Epilepsy
☐	☐	☐	Fainting spells or seizures
☐	☐	☐	Glaucoma
☐	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	☐	Kidney Problems
☐	☐	☐	Mental health disorders

If yes, specify _____

☐	☐	☐	Migraines / severe headaches
☐	☐	☐	Night Sweats
☐	☐	☐	Neurological disorders

- ❍ Post Traumatic Syndrome (PTSD)
- ❍ Traumatic Brain Injury (TB
- ❍ Other _____

Yes	No	Don't Know	
☐	☐	☐	Osteoporosis
☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Respiratory problems.

If yes, specify below:
- ❍ COPD
- ❍ Emphysema
- ❍ Bronchitis, etc.
- ❍ Asthma
- ❍ Tuberculosis

☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Sexually transmitted disease

If yes, specify _____

☐	☐	☐	Sinus trouble
☐	☐	☐	Sleep disorder
☐	☐	☐	Thyroid problems
☐	☐	☐	Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:

_____

_____

Dental Information

Date of your last dental exam _____ Date of last dental x-rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth?_____

NOTE: Both doctor and patient is encouraged to discuss any and all relevant patient health issues prior to treatment.
I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

I authorize the taking of radiographs, study models, photographs, or other diagnostic aids deemed appropriate to aid in the diagnosis of my dental health.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf (if any).

_____ _____

Signature of Patient/Legal Guardian Date Relationship to Patient

For Completion by Dentist / Auxiliary

Comments:

_____

Signature of Dentist / Auxiliary _____ Date _____

BELL BLVD FAMILY DENTAL

ABE TANNER, DDS - MICHAEL FARST, DDS

Welcome to Bell Blvd Family Dental. We look forward to a long and lasting relationship with our patients built on confidence and mutual respect. Please read and sign below.

1. **PARENTS OR GUARDIANS OF MINOR CHILDREN MUST REMAIN ON THE PREMISES WHILE THE DENTIST IS SEEING THEIR CHILD.**

2. COMMITMENT TO APPOINTMENTS: We reserve appointment times for the needs of each individual patient. Our commitment to you is to always strive to be on time. Our office policy is firm in this regard, and we cannot accommodate frequent cancellations or late arrivals. Therefore, if you are more than 15 minutes late, we may ask you to reschedule your appointment, or if you are unable to come to your appointment, we ask that you give us 24-hour notice. ***Failure to keep your scheduled appointment without 24-hour notice will either result in a $25.00 fee being charged to your account or termination of the family's doctor/patient relationship.***

3. TREATMENT ROOMS: To optimize your time while you are being seen, and due to safety and space issues, only one companion is allowed to go back into the treatment area with the patient, and parents are always welcome into the treatment area with their child. For adults being treated that need to bring their child/children to their appointment, we do have a "Kid's Corner" in the waiting room where they can play while you are being seen. Our front office staff will keep a close eye on them. If you do not feel they can play on their own, please arrange for childcare.

4. RETURNED CHECKS: There will be a $25.00 handling fee for any returned check. We do report hot check writers to the Travis County District Attorney.

5. COMMITMENT TO FINANCIAL ARRANGEMENTS: Payment is required on the day of service for all dental treatment. As a convenience to you, our staff will submit charges for services to your insurance carrier. All co-payments for treatment are due on the day of service. The co-payments, which we quote, **are only an estimate.** Any balance, which remains after the insurance payment has been made, is the responsibility of the responsible party. The patient co-payment may be paid in several ways: cash, personal check, Master Card, Visa, Discover, or a payment plan through Care Credit for qualifying patients.

_____ 6. I authorize BELL BLVD FAMILY DENTAL to contact me via current and any future cellular phone
Please initial number(s), or wireless device(s) regarding my delinquent account(s) I owe to BELL BLVD FAMILY DENTAL. I authorize its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account which is past due.

I/We have read these disclosures and agree to the terms described above.

_____ _____

Responsible Party and/or Patient Date

Bell Blvd Family Dental
NOTICE OF PRIVACY PRACTICES

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 09/23/2013, 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.

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.

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.

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 Services.

Our Privacy Official: Bell Blvd Office Manager

Telephone: 512-250-5529 Fax: 512-335-3524

Address: 702 N. Bell Blvd, Cedar Park, TX 78613

E-mail: bellboulevardfamilydental@gmail.com

BELL BLVD FAMILY DENTAL

Acknowledgement Of Receipt Of Notice Of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have read a copy of this office's Notice of Privacy Practices (if you would like a copy of the Notice of Privacy Practices, please let the receptionist know).

Print Name:_____

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

BELL BLVD FAMILY DENTAL

ABE TANNER, DDS - MICHAEL FARST, DDS

Request for Access Of Patient Information

Patient's Name (please print): _____

Date of Birth: _____ (for identification purposes):

Other Family Members:

Patient _____ Relationship to Patient _____ DOB: _____
Patient _____ Relationship to Patient _____ DOB: _____
Patient _____ Relationship to Patient _____ DOB: _____
Patient _____ Relationship to Patient _____ DOB: _____
Patient _____ Relationship to Patient _____ DOB: _____

Describe the records you wish to access and the approximate dates of the records: _____

_____

_____

What would you like for us to do for you?

- o I wish to see the requested records
- o I wish to get a copy of the requested records
- o I wish to see and get a copy of the requested records
- o I wish to have the requested records sent to:
  Name: _____
  Phone No.: _____
  Address: _____
  Email (print very clearly): _____ @ _____
- o I wish to give permission to the following person/people access to my records (print clearly):
- o _____ Relationship to Patient _____ DOB: _____
- o _____ Relationship to Patient _____ DOB: _____

We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

If the request is by a patient:

Patient / Parent Signature _____ Date: _____

If the request is by a patient's personal representative:

Print the Name of Personal Representative: _____

Relationship to Patient: _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____ Date: _____

****

For Office Use Only

Copy of signed authorization provided to the individual: Date: _____ Initials: _____

- o Request for access approved.
- o Request for access denied (attach written denial)
- o Notations made in chart/computer
- o Removed recall
- o Appointment cancelled
- o Copy of records given to above representative

BELL BLVD FAMILY DENTAL

ABE TANNER, DDS - MICHAEL FARST, DDS

Authorization and Consent to Send Unencrypted Patient Information by Email and other Electronic Means

Until I tell you in writing to stop, I authorize **Bell Blvd Family Dental** to transmit patient information relating to my treatment or health by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or **Bell Blvd Family Dental's** health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, or treatment.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, **Bell Blvd Family Dental** may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be disclosed and no longer protected by privacy law.
- **Bell Blvd Family Dental** does not email such sensitive personal information as Social Security Number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that **Bell Blvd Family Dental** already sent before receiving my written instructions to stop.

Patient name (please print): _____

Signature: _____ Date: _____