Date: _____

Personal Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: _____

Preferred Name: _____ Age: _____ DOB: _____ ☐ Male ☐ Female

Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Social Security Number: _____

Phone: Home _____ Cell _____ Best way to contact you: _____

Occupation:_____Employer:_____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Phone: Cell _____ Work _____ Home _____

Dental Insurance

Person responsible for this account: _____ Relationship to patient: _____

Primary Insurance Company: _____ Group number: _____

If Policy Holder is different than patient:
Policy holder's name: _____Policy holder's date of birth: _____

Policy holder's address:_____ Policy holder's phone number:_____

Policy holder's social security number: _____ Relationship to patient:_____

Is patient covered by additional insurance: Yes ☐ No ☐

Secondary Insurance Company: _____ Group number: _____

If Policy Holder is different than patient:
Policy holder's name: _____Policy holder's date of birth: _____

Policy holder's address:_____ Policy holder's phone number:_____

Policy holder's social security number: _____ Relationship to patient:_____

Medical History

Patient Name: _____ **Date of Birth:** _____

Although dental personnel primarily treat the area in and around your mouth, these areas may affect other parts of your body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

☐ Yes ☐ No Are you under a physician's care now? If yes, please explain: _____

☐ Yes ☐ No Have you ever been hospitalized or had major surgery? If yes, please explain: _____

☐ Yes ☐ No Have you ever had a serious head or neck injury? If yes, please explain: _____

☐ Yes ☐ No Are you taking any medications, pill or drugs? If yes, please explain: _____

☐ Yes ☐ No Do you take or have you taken Phen-Fen or Redux?

☐ Yes ☐ No Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

☐ Yes ☐ No Are you on a special diet? ☐ Yes ☐ No Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances?

Women are you:

Pregnant/ Trying to get pregnant? ☐Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Acrylic ☐ Metal ☐ Latex

☐ Sulfa Drugs ☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	□Yes □No	Cortisone Medicine	□Yes □No	Hemophilia	□Yes □No	Radiation Treatments	□Yes □No
Alzheimer's Disease	□Yes □No	Diabetes	□Yes □No	Hepatitis A	□Yes □No	Recent Weight Loss	□Yes □No
Anaphylaxis	□Yes □No	Drug Addiction	□Yes □No	Hepatitis B or C	□Yes □No	Renal Dialysis	□Yes □No
Anemia	□Yes □No	Easily Winded	□Yes □No	Herpes	□Yes □No	Rheumatic Fever	□Yes □No
Angina	□Yes □No	Emphysema	□Yes □No	High Blood Pressure	□Yes □No	Scarlet Fever	□Yes □No
Arthritis/Gout	□Yes □No	Epilepsy/Seizures	□Yes □No	High Cholesterol	□Yes □No	Shingles	□Yes □No
Artificial Heart Valve	□Yes □No	Excessive Bleeding	□Yes □No	Hives or Rash	□Yes □No	Sickle Cell Disease	□Yes □No
Artificial Joint	□Yes □No	Excessive Thirst	□Yes □No	Hypoglycemia	□Yes □No	Sinus Trouble	□Yes □No
Asthma	□Yes □No	Fainting Spell/Dizziness	□Yes □No	Irregular 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 Problem	□Yes □No	Frequent Headaches	□Yes □No	Liver Disease	□Yes □No	Swelling of Limbs	□Yes □No
Bruise Easily	□Yes □No	Genital Herpes	□Yes □No	Low Blood Pressure	□Yes □No	Thyroid Disease	□Yes □No
Cancer	□Yes □No	Glaucoma	□Yes □No	Lung Disease	□Yes □No	Tonsillitis	□Yes □No
Chemotherapy	□Yes □No	Hay Fever	□Yes □No	Mitral Valve Prolepses	□Yes □No	Tuberculosis	□Yes □No
Chest Pains	□Yes □No	Heart Attack/Failure	□Yes □No	Osteoporosis	□Yes □No	Tumors of Growth	□Yes □No
Cold Sore/Fever Blister	□Yes □No	Heart Murmur	□Yes □No	Pain in Jaw Joints	□Yes □No	Ulcers	□Yes □No
Congenital Heart Disorder	□Yes □No	Heart Pacemaker	□Yes □No	Parathyroid	□Yes □No	Venereal Disease	□Yes □No
Convulsions	□Yes □No	Heart Trouble/Disease	□Yes □No	Psychiatric Care	□Yes □No	Yellow Jaundice	□Yes □No

Have you ever had a serious illness not listed above? ☐Yes ☐ No

If yes, please explain: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date _____

Financial Policy

Thank you for choosing our office for your dental care. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa, MasterCard, American Express, Discover Card, or Personal Check (please note $50.00 charge for returned checks)
  *We offer a **5%** courtesy account adjustment to patients who pay for their treatment with cash or check for treatment plans of $1,500 or more*; or
- CareCredit Healthcare Credit Card:
  - Allows you to pay overtime with convenient monthly payment options[1]
  - No annual fees or pre-payment penalties
  - Deferred interest options

Notice to Insurance Patients

- I am responsible for my patient portion prior to the commencement of treatment for myself and dependents
- Lab costs that are incurred due to missed appointments
- If unable to pay in full prior to treatment, I must make financial arrangements with financial coordinator
- Any outstanding balance for prior services must be paid before any other dental work is started
- Dental office will file insurance claim electronically
- *I certify that I (or my dependent) have insurance coverage and assign directly to Gregory Palmer, D.M.D. all insurance benefits, if any, otherwise payable to me for the service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Gregory Palmer, D.M.D. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.*

Notice to Non-Insured Patients

- I am responsible for my balance in full prior to the commencement of treatment for myself and dependents
- If unable to pay in full prior to treatment, I must make financial arrangements with financial coordinator
- Any outstanding balance for prior services must be paid before any other dental work is started

Please note:
Gregory Palmer D.M.D. requires payment prior to the commencement of treatment; if you choose to discontinue care before treatment is completed, your refund, if applicable, will be determined upon review of services/materials/lab fees incurred to date.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

"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.

NOTICE OF PRIVACY PRACTICES

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 the Notice while it is in effect. This Notice takes effect 4.14.03, 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 made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT

We may use or 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 health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters and business planning and development.

Authorization

We may use and disclose your health information to tell you about treatment options or alternatives or health related benefits and services that may be of interest to you.

Family and Friends

We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object, or if you are no present, we believe it is in your best interest to do so.

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 protected 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 reasonably 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 serious threat to your health or safety or that of other persons.

Military Personnel and Nation Security

We may disclose the health information of Armed Forced personnel when required by command military authorities. We may disclose to authorize federal officials' health information required for lawful intelligence, counterintelligence and other national security activities.

Appointment Reminders
We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voice-mail, or email.

Patients Rights

Access
You have the right to look at or get a copy 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. Copies will be provided at the fee of **$25** per set requested. 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 at the end of this Notice for a full explanation of our fee structure.

Accounting of Disclosures
You have the right to receive and accounting of disclosures of your health information for the six year prior to the date that the accounting is requested except for disclosure to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We will charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at any time.

Request a Restriction of Your Protected Health Information
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.

Request Alternative Communications
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 how payments will be handled under the alternative means or location you request.

Amend
If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive a written notice of denial and can file a statement of disagreement that will be included with your health information that you believe in incorrect or incomplete.

Electronic Notice
If you receive this Notice on our website or by email, 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 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 may also submit a written complaint with 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 the U.S. Department of Health and Human Services.

Contact: Stephanie Herrera, Practice Manager

Address: 9113 Stella Link, Suite 1 Houston, TX 77025

Phone Number: 713-375-1777

Fax: 832-383-0022

Email: info@gregorypalmerdmd.com

ACKNOWLEDGMENT OF RECEIPT

of NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices

_____

Please Print Name

_____

Signature

_____

Date

-You may refuse to sign this acknowledgement-

• FOR OFFICE USE ONLY •

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign the acknowledgement
- □ Communication barriers prohibited obtaining the acknowledgement.
- □ An emergency situation prevented us from obtaining the acknowledgement.
- □ Other (Please specify below):

_____

_____

Team Member's Printed Name and Signature

APPOINTMENT AGREEMENT

In order to accommodate requests for appointments from every new, existing and emergency patient and to ensure that we have providers in the practice to accommodate these requests, we ask you to give our practice a minimum of 48 hours' notice if you realize you will be unable to keep your scheduled appointment.

We will not charge for missed appointments. However, after two missed appointments you will be assessed a $50 reservation fee when scheduling the next appointment. If you keep the appointment the reservation fee will be applied towards treatment. However, if you fail to keep the appointment the reservation fee will be forfeited.

Our commitment to excellence is delivered through our high clinical standards as well as our appointment management guidelines. Thank you for agreeing to support our appointment policy.

_____
Patient Name

_____
Patient Signature

_____
Date

CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), hereby authorize Gregory Palmer D.M.D. PC, to take cosmetic photographs, intra-oral photographs, and/or videos of my face, jaws, and teeth before, during, and after treatment. I consent to allow the photographs to be used for the following:

- *Dental records*
- *Dental research*
- *Dental education including lectures, seminars, demonstrations, professional publications such as journals or books*
- *Marketing material including websites, social media, printed materials, and patient education*

I further understand that if the photographs and/or videos are used, ***my name and other identifying information will be kept confidential***. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

☐ Check here if you do not want your full-face shot to be used for any of the above purposes.

Signature (Patient) _____ Date _____

If declining all photographic consent, leave this form blank.