

Welcome



*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.
If you have any questions or need assistance,
please ask us - we will be happy to help.*

PATIENT INFORMATION

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Sex M F Married Widowed Single Minor Divorced

Email _____ Cell Phone #1 _____ Cell Phone #2 _____

Employer / School _____ Employer / School Phone _____

Employer / School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____

Work Phone _____ Cell Phone _____

Person to contact in case of emergency _____ Home Phone _____ Cell _____

RESPONSIBILITY

Name of Person responsible for this account _____ Relation to Patient _____

Address _____ Home Phone _____

Drivers License # _____ Birthdate _____

Employer _____ Work phone _____

Currently a patient in our office? Yes No Email _____ Cell Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Address _____ City _____ State _____ Zip _____

Insurance Phone Numbers _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Address _____ City _____ State _____ Zip _____

Insurance Phone Numbers _____

DENTAL HISTORY

Reason for today's visit _____

Date of last dental visit _____ Date of last dental x-rays? _____

How often do you brush? _____ How often do you floss? _____

What texture toothbrush do you use? _____ Do you use fluoride supplements? _____

Please check (✓) any of the following that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grind or clench teeth | <input type="checkbox"/> Pain Around Ear |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Gums swollen or tender | <input type="checkbox"/> Periodontic Treatment |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Jaw pain or tenderness | <input type="checkbox"/> Sensitivity to heat, cold, sweets |
| <input type="checkbox"/> Complications from Extractions | <input type="checkbox"/> Loose teeth or fillings | <input type="checkbox"/> Teeth replaced by Bridge or Crown |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Teeth replaced by Full/Partial Denture |
| <input type="checkbox"/> Food collects between teeth | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Unfavorable Dental Experience |
| | | <input type="checkbox"/> Other _____ |

Comments _____

MEDICAL HISTORY

Physician's Name _____ Office Phone _____ Last Visit _____

Have you had any serious illnesses or operations? Yes No Describe _____

Have you ever taken Bisphosphonate drugs such as Fosamax, Actonel, or Boniva? Yes No Which _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

Check (✓) if you have or had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Glaucoma / Eye Disorders | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Joints _____ | <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinus Trouble / Allergies |
| <input type="checkbox"/> Abnormal Bleeding from Cuts, Extractions | <input type="checkbox"/> Hepatitis: Type _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |

List any medications you are currently taking: _____

Allergies: List any medications you are allergic to (example - antibiotics, anesthetics, aspirin, codeine, penicillin, etc.): _____

Authorization and Release: To the best of my knowledge, the above information is true and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health or medication.

Signature of Patient (or Parent/Guardian) _____ Date _____

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

Melanie Billimek Cowan, D.D.S.

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 09/01/2003, 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 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, payment of 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 while 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.

TO YOUR FAMILY AND FRIENDS: 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 help with your healthcare or with payment for 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 based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's 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 reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We 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 personal 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 of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose 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 get 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 a 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 \$0. 25 for each page, \$30 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 associates 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 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

RESTRICION: 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 restrctions, 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 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 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 use 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.

Contact Officer: Melanie Billimek Cowan, D.D.S.

Telephone: 361-594-2800

Address: P.O. Box 556 – 711 N. Ave D
Shiner, TX 77984

Fax: 361-594-4109

Melaine Billimek Cowan, D.D.S.

Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

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

Please 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 acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

Melaine Billimek Cowan, D.D.S.

Office Financial Policy

In order to provide the quality of care that you desire and minimize administrative costs, it is necessary to have an understanding between our families and the office regarding payment for services. We will discuss all treatment and fees with you. The office accepts the following forms of payment: Cash, Check, VISA, MasterCard, Discover, and Insurance assignment.

FAMILIES WITH NO DENTAL INSURANCE (CASH PAY)

Full payment is due at each visit per services rendered.

FAMILIES WITH DENTAL INSURANCE

You must provide your insurance I.D. card at your appointment. We must have a copy of your insurance card on file. We must have the policy ID number, group number, telephone numbers, and address information regarding where to file the claim. Without this information we will be unable to file the claim.

You assign the benefits to the office and we file the insurance. Payment will come directly to our office.

**** At the time of your visit we will require you to pay the estimated portion that your insurance does not pay.****

If benefits are denied or no response is received within 60 days of filing, the balance is due and payable by the family. The final responsibility for the account remains with the family.

If you are unable to provide your insurance information at your dental visit, full payment will be due at each visit per services rendered.

FAMILIES WITH DISCOUNT DENTAL PLANS

Our office does not participate in any discount plans. Full payment will be due at each visit per services rendered.

**** A \$25.00 charge will be assessed on all returned checks to our office.****

Acknowledgement: I, the undersigned, have read and fully understand the contents of this policy. I understand that should this account become delinquent I will be responsible for any and all legal fees, court costs, or collection fees involved as a result of any collection activity.

Patient/Parent/Guardian _____ Date _____