Smithson Valley
FAMILY DENTISTRY

Date:_____

Name:_____ Prefer to be called:_____ □ Male □ Female

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

Primary Phone:_____ Secondary Phone:_____ Email:_____

DOB:_____ Driver's License:_____ SSN:_____

Marital Status: □ Married □ Single □ Divorced □ Other □ Minor Contact preference: □ Call □ Text □ E-mail

Emergency Contact:_____ Phone:_____ Relationship to patient:_____

Person financially responsible for this account? _____ Relationship:_____

How did you hear about our office? _____

Primary Insurance:

Name of Insured:_____ DOB:_____ Relationship to Patient:_____

Dental Insurance Co.:_____ Group #:_____ ID#/SSN:_____

Medical Insurance Co.:_____ Group#_____ ID#:_____

Employer:_____ Occupation:_____

Secondary Insurance:

Name of Insured:_____ DOB:_____ Relationship to Patient:_____

Dental Insurance Co.:_____ Group #:_____ ID#/SSN:_____

Medical Insurance Co.:_____ Group#_____ ID#:_____

Employer:_____ Occupation:_____

Dental History:

Reason for today's visit?_____ Last dental visit? _____

Have you ever had any serious problems with previous dental treatment?_____

Do you feel discomfort in any of your teeth? _____ Do your gums bleed when you brush or floss?_____

Do you grind your teeth? _____ Do you have joint/jaw pain?_____

Please rate your anxiety level for dental visits? _____ love dental visits _____ somewhat anxious _____ very anxious

_____hate dental visits (prefer sedation for all dental treatment)

Any other questions/concerns that have not been covered above? _____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Smithson Valley Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize Dr. Wright to perform any necessary examination and radiographs needed for proper diagnosis.

Responsible Party Signature:_____ Date:_____ Relationship:_____

Smithson Valley
FAMILY DENTISTRY

Patient Name:_____

MEDICAL HISTORY

Please circle (Y) for "yes", or (N) for "no" for any of the following which may apply to you now, or in the past:

Y N Heart Attack or Heart Trouble
Y N Congenital Heart Disease
Y N Chest Pain with exercise (angina)
Y N High Blood Pressure
Y N Heart Valve Disorder
Y N Pacemaker
Y N Psychiatric Disorders

Y N Implant or Artificial Joint
When? _____
Y N Anemia or Blood Disorder
Y N Excessive Bleeding
Y N Diabetes
Y N Stroke
Y N Use Tobacco?

Y N Thyroid Disease
Y N Asthma
Y N Ulcers, Reflux, Heartburn
Y N Digestive Disorders
Y N Kidney Problems
Y N Fainting or Blackouts
Y N Drug/Alcohol Dependency

Y N Headaches or Migraines
Y N Epilepsy or Seizures
Y N Tumors, Cancer, Radiation
Y N Tuberculosis, Lung Problems
Y N Hepatitis A B C D
Y N AIDS or HIV Infection

Are you currently, or have you ever taken oral or IV bisphosphonates for osteoporosis? Y N

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? Y N

If yes, please explain _____

Have you ever had an allergic reaction to an anesthetic or drug such as penicillin, sedative, latex, aspirin, or metals? Y N

If yes, please explain _____

Please list any prescription or over the counter drugs, medications, or vitamins you are currently taking:

Are you currently pregnant?_____ If yes, when are you expecting?_____

Smithson Valley Family Dentistry along with our preferred specialist offer a variety of services to enhance your comfort and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

In Office Whitening
Take Home Whitening Trays
IV Sedation
Invisalign

Traditional Braces
Veneers
Sealants
Implants

Partials/Dentures
Nighttime/Sports/Sleep Apnea Appliances
Extended Payment Plans

Responsible Party Signature:_____ Date:_____

Doctor/Hygienist Signature:_____Date:_____

Television preference _____ Sports _____ News _____Movie _____ No TV

Dental Marketing Release

Smithson Valley Family Dentistry
18636 Forty Six Parkway
Spring Branch, TX 78070
830-217-7000
admin@SVFamilyDentistry.com

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for educational and/or marketing purposes by Smithson Valley Family Dentistry. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations. I understand that I will not receive financial compensation.

Purpose:
My photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing addressed to the practice. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 20 years from date signed.

Patient Name: _____ Date: _____

Patient Signature: _____

FINANCIAL POLICY
Smithson Valley Family Dentistry - Dr. Jared Wright

Assignment and Release
I the undersigned, have insurance with _____, and assign directly to Smithson Valley Family Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided to my child by Smithson Valley Family Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 48 hours prior to my child's scheduled appointment time. We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your child's reserved dental appointment.

I understand that for any treatment less than three hundred dollars ($300) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____

Minor/Child Consent
I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

HIPAA- PATIENT ACKNOWLEDGEMENT FORM

Smithson Valley Family Dentistry's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Smithson Valley Family Dentistry to leave a message or an email regarding an appointment at:

Home: _____and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Smithson Valley Family Dentistry to share medical/dental information with:

1. Name: _____ Relationship: _____

   Phone: _____

2. Name: _____ Relationship: _____

   Phone: _____

3. Name: _____ Relationship: _____

   Phone: _____

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): _____ Date: _____

Signature of Parent or Legal Guardian: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USEDAND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Smithson Valley Family Dentistry is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information, referred to as "PHI," to carry out treatment, payment or office procedures and for other purposes that are permitted or required by law. This notice is effective 1/29/18. You may access or obtain a copy according to the following options: 1) our website at www.olentangymoderndental.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

Get an electronic or paper copy of your medical/dental record: You can ask to see or get an electronic or paper copy of your PHI. Ask us how to do this. We will provide a copy or a summary of your health information within 30 days of your request. We may charge a reasonable fee.

Ask us to amend your medical record: You have the right to request we amend your health information that you believe to be incomplete or incorrect. We may deny your request, but we will provide you an explanation in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home, office or cell phone) or to send mail to a different address. We will accommodate all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment or office procedures. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or healthcare item out of pocket, in full, you can ask us not to share that information for the purpose of payment or our operations with your insurance provider.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your PHI for six (6) years prior to the date you ask, who we shared it with and why. We will include all disclosures except for those about treatment, payment and office procedures, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but may charge a reasonable fee if you ask for another one within twelve (12) months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney, that person can exercise your rights and make choices about your health information. We will make sure that person has authority and can act for you before we take any action.

File a complaint: You can file a complaint if you feel we have violated your rights by contacting:

Smithson Valley Family Dentistry
18636 Forty Six Parkway
Spring Branch, TX 78070
830-217-7000
admin@SVFamilyDentistry.com

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20210, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.

We will not retaliate against you for filing a complaint.

In these cases, you have both the right and choice to:

- Share information with your family, friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are unable to tell us your preferences, we may go ahead and share your information if we believe it's in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OTHER USES AND DISCLOSURES: How do we typically use or share your PHI? We typically use or share PHI information in the following ways.

Treatment of your child. We can use your PHI and share it with other professionals who are treating him/her.

Run our practice. We can use and share your PHI to run our practice, improve your care and contact you when necessary.

Bill for services. We can use and share your PHI to bill and get payment from insurance plans or other entities.

How else can we use or share your PHI? We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/concon/index.html

Help with public health and safety issues. We can share PHI about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence and preventing or reducing a serious threat to anyone's health or safety.

Comply with the law. We will share information about you if state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with the federal privacy law.

Work with a medical examiner or funeral director. We can share information with a coroner, medical examiner or funeral director when an individual dies.

Address law enforcement and other government requests. We can use or share PHI for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law and for special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions. We can share PHI about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your PHI. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

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