ELITE DENTAL ASSOCIATES

Dallas Uptown – (214) 220-2424

Patient Name: _____ Date: _____/_____/_____
First Last M.I.

Gender: M / F Married: Y / N SSN: _____ DOB: _____/_____/_____

Who may we thank for referring you to our practice?_____

Patient Address: _____
Street City State Zip

Home #: (_____)_____ Work #: (_____)_____ Ext: _____

Cell #: (_____)_____ Email: _____

Which is best for confirmation? Email _____ Home# _____ Work# _____ Cell# _____

Physician: _____ _____
Name Phone #

Pharmacy: _____ _____
Name Phone #

Emergency Contact: _____ _____
Name Phone #

Former Dentist: _____ City/State: _____

Date of Last Dental Visit: _____ Date of Last Dental X-rays: _____

Reason for Last Dental Visit: _____

_____

Dental Insurance (If any)

Insurance Company _____ Ins. Ph #: _____

Subscriber's Name _____ DOB: _____/_____/_____

SS# or I.D. # _____ Relationship to Patient _____

Subscriber's Employer _____ Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Elite Dental Associates and its affiliates 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 they are paid for by insurance. I authorize the use of my signature on all insurance submissions. **Please be advised that due to the nature of our business, we require a 48 hour cancellation notice or a $45.00 fee may apply.**

The above named office and/or doctor may use my health care information and may disclose such information to the above-named insurance. Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed and balance is paid-in-full or two years from the date signed below.

_____ _____ _____/_____/_____
Signature of Patient, Parent, Guardian or PR Please print name of Patient, Parent, Guardian, or PR Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any 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 _____

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1. NEW PATIENT APPOINTMENT

I understand that I am a new patient at Elite Dental Associates. The following procedure will be performed at my first visit:
Complete New Patient Oral/Perio Evaluation_X_ Oral Cancer Screening_X_ Periodontal Screening_X_. Prophy/Cleaning or Full Mouth Debridement (Periodontal Patients)_X_ All Necessary X-Rays/Radiograph/Photography of Treatment_X_.

Initial Blood Pressure _____ Pulse _____

(Patient Initial_____) (Staff _____)

*Please note that we believe in the benefit of in-office concentrated fluoride treatment after preventive care. The **American Dental Association** has continuously endorsed the use of fluoride-containing products as safe and effective measures for preventing tooth decay but vast majority of insurance companies do **NOT** cover this expense for adults. We believe the benefits of fluoride outweigh the minimal cost of **$24** for this application. You, as a patient, have the right to decide on this benefit. Please initial below on your acceptance or decline of this highly beneficial fluoride treatment. If you are parent or guardian of a patient under the age of 18, please initial below on their behalf.*

(Acceptance Initial_____) (Decline Initial_____)

2. DRUGS AND MEDICATIONS

I understand that antibiotics, analgesics, nitrous oxide, antibiotic pre-med, oral conscious sedation meds and other medications administered by our doctors can cause allergic reactions causing redness, bruising, and swelling of tissue in the mouth and/or on the facial tissue, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) which may require hospitalization ***at the cost to the patient***; I also understand that our doctors will base his professional administration of drugs & medication based on the medical history and drug allergy provided by me on the patient information form. I absolve all members/employees of Elite Dental Associates of all responsibility if medication is not taken as prescribed. I agree not to operate a motor vehicle or hazardous device for at least 24 hours or more until fully recovered from the effects of the anesthesia or drugs prescribed for my care.

OPTIONAL: You may choose to add NITROUS OXIDE ANALGESIA as a *supplement* to local anesthesia. The cost for this procedure is *$67 per session or dental visit*. Use of nitrous oxide requires that we obtain your consent.

NITROUS OXIDE is also known as "laughing gas." You will be relaxed and somewhat less aware of your surroundings, as well as less responsive to minor discomfort, and you may or may not recall much of the procedure. Nitrous oxide is breathed through a nasal mask and, after a state of relaxation is reached, local anesthesia is administered. Nitrous oxide has few lasting effects, and you usually may drive safely after a fairly brief recovery time. However, for safety precautions, its use does require some preparation on your part. Thus, it is important that you read and understand the information below and that you prepare by following the instructions carefully. If you are unclear about anything, please ask your doctor.

1. Recovery time from nitrous oxide is usually very short, but may be prolonged, requiring you to remain in the office for some time after surgery. Rarely, you may be unable to drive home alone. Thus, it is best to arrange for a responsible friend or family member to be "on call" for such a possibility.
2. Although not usually required, it may be best to have a responsible adult accompany you to drive you home.
3. You may have a light meal a few hours prior to surgery.
4. Plan to rest for the remainder of the day.

I understand that the use of nitrous oxide, although usually safe and without lasting consequences, may effect me differently. I am prepared to deal with any undesirable side effects of nitrous oxide and understand that those possibilities listed above, as well as others not considered, may occur. I agree to the use of Nitrous Oxide analgesia ("Laughing Gas") to supplement the local anesthesia planned for my procedure.

Female Patients: It has also been explained to me, and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed.

(Patient Initial_____) (Staff_____)

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change, add or delete procedures because of the conditions found while working on the teeth that were not able to be discovered during our oral and x-ray examination; the most common being root canal therapy following routine restorative procedures (i.e. Fillings, crowns, etc). I give my permission and trust to the treating doctor to make any/all changes and additions as necessary for the best interest of my dental health. Fees for additional procedure will apply and I will be responsible for that additional cost.
Note: X-Rays may need to taken before, during and/or after treatment per your insurance coverage or in-office document; these x-rays are required by the insurance companies to obtain your coverage; most insurance companies cover this additional cost but if your insurance does not cover this cost, you are responsible for the fees involved in obtaining these required x-rays.

(Patient Initial_____) (Staff_____)

Patient/GuardianSignature_____Date:_____

Witness/Staff_____Date:_____

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OFFICE and FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our greatest concern is your complete oral health. Anything we do or say will be centered on that philosophy. It is suggested that each patient is seen every six months (or as needed based on dental health) to ensure this preventive philosophy is met. We are committed to your treatment being successful, and to the return and maintenance of your good oral health.

Please understand that payment of your bill is considered part of that treatment. ***We do realize that financial concerns are unavoidable and we are not here to trade a "dental problem" with a "financial problem".*** We therefore offer the following financial options. We will be happy to work with you to plan the most appropriate arrangements for you. We want you to be able to enjoy the benefits of dental health.

We must emphasize that as a dental care provider, our relationship is with YOU and NOT with your insurance company. Our office philosophy is to provide the highest quality dentistry for each and every one of our patients, regardless of their insurance limitations.

Emergency dental treatment is intended to provide relief of severe pain and infection to individuals in acute need. You as a patient of record have access to 24-hour phone emergency service. There will be a charge for this service if you are a new patient and for existing patients, a fee may apply based on the service rendered if an office visit is required.

The following is a statement of our Financial Policy, which we ask you to read, initial and sign prior to any treatment.

_____ **PAYMENT FOR SERVICES RENDERED:** Patients are responsible for payment of all services rendered on their behalf or their dependents. Payment is due at the time of service unless other financial arrangements have been made in writing in advanced.

NOTE: We reserve the right to charge an ***18% interest rate on all balances past 30 days –***
If your insurance company has not paid your balance full within 30 days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. Our office cannot render services on the assumption that your treatment will be paid by your insurance company.

_____ **INSURANCE ASSIGNMENT:** We may accept assignment of insurance benefits; however, most insurance plans do not cover 100% of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, please keep in mind that some, and perhaps all, of the services are not considered reasonable and necessary under the provisions of your insurance plan. In the instance that our office accepts your insurance companies' assignment, **it does NOT absolve the patient's responsibility** for the charges of the treatment rendered. We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of service. **Your insurance policy is a contract between you and your insurance company. We are not a party to that company's assignment.**

If secondary insurance is involved, we will gladly help you obtain your maximum benefit under the secondary plan by providing you all necessary forms and/or x-rays required for you to file. We, though, cannot accept secondary insurance as possible payment for services since "double" insurance does not necessarily mean that both insurance companies will cover all expenses involve with your treatment.

_____ **INSURANCE FACTS:** Most insurance companies have a yearly deductible. You will need to know what your deductible is and pay that amount before your insurance company will begin to pay benefits. In cases involving lab fees, we reserve the right to require a deposit to cover outside lab expenses.

_____ **DEFAULT ON PAYMENT:** In the event of default on payment, the patient (guardian) promises to pay a ***service fee*** in the amount of ***$125*** in addition any collection agency fees, court and attorney cost to the balance owed.

Please note the actions that will be taken by our office in the event of "default of payment":

- **After 60 days of non-payment from insurance company**, the balance will be transferred to the patient's account and payment is required in 30 days; if insurance is not involved, *payment is due at the time of service unless other financial arrangements have been made in writing.*
- **After 75 days of non-payment**, patient's account will be transferred to a collection agency for collection; please note that at this point, ***possible effects can occur on your credit report which in turn can have a negative effect on your ability to purchase certain items utilizing credit (ie. Auto, Houses, etc.).***
- **After 90 days of non-payment**, account will be transferred to your local ***County Clerk Office – Small Claims Court*** for collection of balance due; *"Abstract of Judgment"* will be obtained and this recorded judgment may be picked up by credit companies, title companies, lawyers or any outside party who checks for judgments on lien records.

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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 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 this Notice about our privacy practices, and 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 immediately 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 in this Notice.

QUESTIONS AND COMPLAINTS

If you want more information to our privacy practices or has 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 of disclosure of your health information or to have us communicate with you by alternative means or 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 Office for Civil Rights. We will provide you with the address to file your complaint with the Office for Civil Rights 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 your complaint with the Privacy officer or with the Office for Civil Rights.

Privacy Officer:	Office Managers
Telephone:	(214) 220-2424
Address:	2410 McKinney Avenue Dallas, Texas 75201

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 and 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 or healthcare operations, you may give us written authorization to use your healthcare 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 Friends and Family
We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose 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 the use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to 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 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 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 or 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 practically do so. You must make request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. *We will charge you $55 per set of x-rays and molds, $1.00 for each page copied and $20 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed*. If you request an alternative format (via email), we will charge a cost base fee of $35 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 in this Notice for a full explanation of our fee structure.

NOTE: This is dictated by the U.S.Government and part of the Privacy Act

Patient Initial _____

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.

Restrictions
You have the right to request that we place additional restrictions on our use of 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 Communications
You have the right to request that we communicate with you about your health information by alternative means, or 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 at that location.

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.

Patient(s) _____

Responsible Party Signature _____ Date: _____
(Parent/Guardian if patient is a minor)