PATIENT INFORMATION

Patient Name _____ **Preferred Name** _____
Last **First** **M**

Date of Birth _____ **Social Security #** _____ **DL/ID #** _____

❑ **Married** ❑ **Single** ❑ **Child** ❑ **Other** **Gender** ❑ **Male** ❑ **Female** **Weight** _____ **Height** _____

Phone (Home) _____ **Work** _____ **Cell** _____

Address _____ **Email** _____
City **ST** **ZIP**

MEDICAL HISTORY

Have you ever had any of the following? Please check all those that apply:

- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Aspirin Allergy
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Codeine Allergy
- ❑ Diabetes: Type
- ❑ Dizziness
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis _____
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Mental Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Penicillin Allergy
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Seasonal Allergies
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Taking Aspirin Daily
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease

Osteoporosis Medication (ex. Fosamax, Actonel, Boniva, Aredia, Zometa) ❑ Yes ❑ No
FOR WOMEN ONLY: Are you taking birth control? ❑ Yes ❑ No **Are you pregnant?** ❑ Yes ❑ No
Are you allergic to any medication, or have you ever had an allergic reaction to a medication? ❑ Yes ❑ No

If yes, please describe _____

Are you taking any medications at this time? ❑ Yes ❑ No **If yes, please describe** _____
Have you ever had to pre-medicate with antibiotics for dental treatments? ❑ Yes ❑ No
Have you ever had any complications following dental treatments? ❑ Yes ❑ No

If yes, please describe _____
Have you been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No

If yes, please describe _____

Previous surgeries _____

Are you now under the care of a physician? ❑ Yes ❑ No **If yes, please describe** _____

Name of Physician _____ **Phone #** _____
Do you have any health problems that need further clarification? ❑ Yes ❑ No

If yes, please describe _____

Do you use tobacco? ❑ Yes ❑ No **If yes, what & how often?** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail.

Signature of patient, parent, or guardian _____ **Date** _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for ❑ the patient's spouse ❑ the person responsible for payment

Name _____ **Preferred Name** _____
Last **First** **M**

Date of Birth _____ **Social Security #** _____ **DL/ID #** _____

❑ Married ❑ Single ❑ Child ❑ Other **Gender ❑ Male ❑ Female**

Phone (Home) _____ **Work** _____ **Cell** _____

Address _____ **Email** _____
City **ST** **ZIP**

DENTAL INSURANCE INFORMATION

Insurance Plan Name _____

Address _____

Name of Insured _____ **Insured's Birth Date** _____

Relationship to patient _____

Phone # of Insured _____ **Insured's Social Security #** _____

Insured's Address _____

Insured's Employer _____

Insurance Phone # _____

Insurance Group # _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will file the claims to the insurance companies and help with phone calls to them when necessary. All quotes given from insurance companies are just estimates and are NEVER a guarantee of payment. This office will send pre-estimates to the insurance companies if requested by patient. Patient's estimated co-pay will be due at the date of service unless other arrangements have been made. Any claim not paid within 45 days of the date of service will then be the patient's responsibility. The balance not paid by the insurance will be due by the patient.

_____ I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

_____ I grant my permission to you or you assignee, to telephone me at home or at my work to discuss matters related to this form.

_____ I understand that I am completely responsible for the payment of all expenses incurred. I assign and authorize Jason D. Roe, DDS, PLLC payment of any and all benefits payable by Insurance and the necessary release of medical information needed to process all insurance claims. In the event of non-payment I agree to bear the cost of collection and/or court costs and reasonable legal fees not to exceed 50% of the unpaid balance. The undersigned waives rights of exemption under the state of Texas. Payment is required at the time of Service!

I hereby authorize any treatment deemed necessary by Jason D Roe, DDS, FACP.

_____ _____

Patient Signature/Responsible Party *Date*

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.

I also authorize Dr. Jason Roe and his staff to discuss my medical care with the following individual(s) listed below. If there are any limitations on what we may discuss with these individuals, it must be received in writing and will be added to your file. This will remain in force unless revoked in writing.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

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**
- ❑ **Communication barriers prohibited obtaining the acknowledgement**
- ❑ **An emergency situation prevented us from obtaining acknowledgement**
- ❑ **Other (Please specify)**

_____

PRACTICE POLICIES

We are honored that you have chosen us to provide your dental care. We are here to help you and below are some general guidelines for our office

General

- **Patients are seen by appointment only.**
- **Office hours are Monday through Thursday 8:00 – 4:00, and we are closed for lunch from 12:00 – 1:00.**
- **Cancellations within 24 hours of your appointment will be charged a fee of $50 for the first occurrence and $75 for any future occurrences. If you need to cancel or reschedule your appointment, please verbally notify us at least 48 business hours in advance. We do not accept changes to the schedule on our voicemail system.**
- **"No Show" appointments will be charged your appointment fee in full starting with a minimum of $150.**
- **After the first "No Show" appointment, all other appointments will need to be pre-paid in full at the time the appointment is scheduled.**
- **If a patient has three (3) last-minute cancellations or missed appointments in a twelve-month period of time, we reserve the right to terminate the patient/doctor relationship.**
- **As a courtesy to you, all appointments will receive a 2-week reminder from our office. At that time, we ask that you confirm the appointment, and update our office of any changes in your contact information, or insurance information.**

Payments

- **We accept American Express, Master Card, Visa and Discover**
- **For your convenience, our office offers third party financing through Care Credit Corporation and 12 month No Interest is available.**
- **Payments for services are to be paid at the time services are rendered.**

Insurance

- **To better assist you, we do require all insurance information and verification 48 hours prior to your appointment time.**
- **As we are not contracted with dental insurance companies, your insurance will reimburse you directly for services rendered in our office. We will file claims as a courtesy to you; however, all fees are ultimately the responsibility of the patient regardless of insurance.**

_____

Patient Name

_____ _____

Patient Signature *Date*

NOTICE OF PRIVACY POLICIES

Jason D. Roe, DDS, PLLC

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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 04/15/2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Office Manager/Dr. Roe. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your

information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $35 for each page and the staff time charged will be $15 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore, these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restriction Disclosure to a Health Plan: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions except in emergencies or if the following two criteria are met: 1) if the patient asks the dental practice not to disclose information about a health care item to a health plan for payment or operations purposes, and 2) the dental practice has been paid in full for the item or

the service by the patient or by another on behalf of the patient. Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach notification: The practice is required by law to notify affected individuals following a breach of unsecured patient information.

Authorizations/Marketing and sale of PHI: The practice cannot sell patient information without the patient's express written authorization, and that authorization is also required for certain marketing communications. Other uses and disclosures not described in the Notice of Privacy Practices will be made only with the patient's written authorization. The patient may revoke an authorization at any time, as long as the patient does so in writing, but:1) if the dental practice has already relied on the authorization to use or disclose patient information the revocation cannot apply to those uses or discloses, and 2) if the authorization was for purposes of obtaining insurance coverage, other law gives the insurance company certain rights.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

HOW TO CONTACT US

Practice Name:	Pro Dental Dallas / Jason D. Roe, DDS, PLLC
Privacy Officer:	Jason Roe, DDS
Telephone:	(972) 931-1777
Fax:	(972) 931-8259
Email:	office@prodentaldallas.com
Website:	prodentaldallas.com
Address:	5136 Village Creek Dr #501 Plano, TX 75093

PATIENT INFORMATION					
Name:				Date:	
Pharmacy of Choice:				Phone Number (if available):	

CURRENT MEDICATION REGIMEN

Name of medication:	Dosage / Freq.		Current condition being treated?	Physician prescribing medication:	Physician's address & phone #:
EXAMPLE: Lipitor	80mg	1 daily	Cholesterol	Dr. Smith	XXX Louis Dr. – Dallas 972-XXX-XXXX

Are you taking or have you recently taken any over the counter medicine(s)? ..... ☐ Yes ☐ No ☐ Don't know
If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements: