Pearson Family Dentistry

Nurturing Healthy Smiles

Patient Information

Patient's Name:_____
Last First Middle Preference

Birthdate: _____ Male/Female: _____ Marital Status: _____

Social Security #: _____ Driver's License #: _____ State: _____

Address:_____
Street Apt. # City State Zip

(Please provide all telephone numbers to contact you. There may be times when we need to reach you on short notice.)

Home: _____ Work: _____ ext _____ Cell: _____

Email Address: _____Employer: _____

Spouse's Name: _____ Birthdate: _____ Social Security #: _____

Spouse's Employer: _____ Spouse's Work Ph: _____

Is an immediate family member a patient here: _____ Name: _____

How did you hear about us? _____

Responsible Party Information

Self: _____Other:_____
Last First Middle

If "Other," please complete: Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Driver's License #: _____

Address: _____
Street Apt. # City State Zip

Home Ph: _____ Work Ph: _____

Emergency Contact Information:

Name of nearest relative not living with you: _____ Phone: _____

Address: _____
Street Apt. # City State Zip

Financial Policy

At it is our mission to provide the best possible dental care for our patients. In an effort to keep our fees affordable, we have adopted a no open billing policy. Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks/debit cards, Visa, MasterCard, American Express and Discover Card. For patients with dental insurance, we will gladly accept assignment of your insurance benefits if you provide us with accurate information. We make every effort to closely estimate for you what your insurance coverage will be for your treatment. However, there are times when insurance underpays or denies payment on a claim for a variety of reasons. Any remaining balance not paid by insurance within 60 days for any reason will become the responsibility of the patient or the patient's guardian if the patient is a minor. Your signature below indicates that you have read, understand, and agree to this policy.

Patient's Signature: _____ Date: _____

Parent/Guardian signature if patient is a minor: _____

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1. Are you experiencing pain or discomfort? ..... Y N

2. Are you in good health? ..... Y N

3. Have you been hospitalized or had a serious operation or illness within the past 5 years?..... Y N

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4. Are you under the care of a physician? ..... Y N

If so, what condition is being treated? _____

Physician's Name: _____ Phone #: _____

Address:_____

5. Do you have or have you had any of the following diseases or problems? Please circle:

Heart Failure	Asthma	Ulcers
Heart Disease or Attack	Chemotherapy (Cancer, Leukemia)	Cold Sores
Angina Pectoris	Hay Fever	HIV Positive
Heart Murmur	Arthritis	Bruise Easily
Artificial Heart Valve	Rheumatic Fever	STD or VD (Syphilis, Gonorrhea)
Congenital Heart Defect	Sinus Trouble	Hepatitis A (Infectious)
Heart Pacemaker	Rheumatism	Hepatitis B (Serum)
Heart Surgery _____	Allergies or Hives	Hepatitis C
Mitral Valve Prolapse	Cortisone Medicine	Sickle Cell Disease
Stent Placement_____	Scarlet Fever	Blood Transfusion
Emphysema	Glaucoma	Psychiatric Treatment
Diabetes	Anemia	Yellow Jaundice
Cough	Pain in Jaw Joints	Liver Disease
Thyroid Disease	Stroke	Nervousness
Tuberculosis (TB)	Fainting or Dizzy Spells	Replacement/Artificial Joint
X-Ray or Cobalt Treatment	Kidney Trouble_____	type_____yr placed_____
High Blood Pressure	Epilepsy or Seizures	

6. Do you have a disease, condition, or problem not listed above that you think I should know?..... Y N

If yes, please explain_____

7. Are you taking any drug, medicine or herbal supplement? ..... Y N

If so, what:_____

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8. Are you taking a daily aspirin or other blood thinner? ..... Y N

9. Are you allergic or have you reacted adversely to any drugs or medicines? ..... Y N

If so, which drugs? _____

Aspirin	Erythromycin	Local Anesthetic
Codeine	Penicillin	Nitrous Oxide
Darvon	Tetracycline	Other Antibiotics
Valium		

10. Have you had previous skin reactions to jewelry or know of an allergy to any metal? ..... Y N

11. Have you had any serious trouble associated with any previous dental treatment?..... Y N

12. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ..... Y N

14. FOR WOMEN ONLY: ARE YOU PREGNANT? ..... Y N Are you taking any form of birth control? .....Y N

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Appointment Policy

Confirming Appointments

As a courtesy to our patients, we will call and confirm your appointment 24 hours in advance. If we are unable to contact you, we still expect you to arrive for your appointment

Arriving Late

Because our office takes great care in scheduling appointments for all of our patients, arriving late for an appointment may result in us not being able to start or complete treatment in the remaining amount of time. To provide you with proper dental care, it may be necessary to reschedule your appointment.

Cancellations

We schedule a specific amount of time with the doctor or hygienist. This time is scheduled just for you and we ask that you give us at least 24 hours advanced notice if you want to cancel or change your appointment.

We do understand that emergencies do arise or that we may have to reschedule if one of our staff members calls in sick. When you do not notify us of your inability to keep an appointment, another patient in need of dentistry or waiting for an appointment is prevented from receiving treatment.

After a patient has failed two appointments, that patient will be required to make a $50.00 non-refundable appointment deposit. This deposit will be used toward treatment for that specific appointment. However, if the patient fails their appointment they forfeit the amount of the deposit.

I have read and understand the appointment policy of Aycox & Pearson Family Dentistry

Patient Name _____

Patient/Guardian Signature _____

Date _____

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FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

If necessary, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice, at any time by contacting our office at 307 E. Ovilla Rd Suite 400 Red Oak, TX 75154 Phone Number 972-576-0602.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice. Your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, we may decline to treat you or continue treating you if you revoke this Consent.

I , _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**You may refuse to sign this acknowledgement **

ACKNOWLEDGEMENT 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: _____

Please keep this copy for your 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 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 April 14, 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 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 or 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 identify 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 your 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.

Please keep this copy for your records.

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 of 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 of 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 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 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 requested copies, we have the right to charge you $0.05 for each page, $15.00 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.

Restriction: 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 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 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 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 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.

IF YOU WANT MORE INFORMATION ABOUT OUR PRIVACY PRACTICES OR HAVE QUESTIONS OR CONCERNS, PLEASE CONTACT PEARSON FAMILY DENTISTRY
307 E. Ovilla Rd Suite 400 Red Oak, TX 75154 PHONE 972-576-0602.

ViziLite® Plus
ORAL LESION IDENTIFICATION AND MARKING SYSTEM
Better screening saves lives™
WITH TBLUE 630™
ZOLA TOLONIUM CHLORIDE

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors**. Oral cancer risk by patient profile is as follows:

Increased risk: *patients ages 18-39*
High risk: *patients age 40 and older; tobacco users (any age, any type within 10 years)*
Highest risk: *patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is $45.00

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: _____

Signature: _____ Date: _____

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____