Lindsay Dental Group, PLLC

PATIENT INFORMATION

Today's Date ____/____/____ Reason for Today's Visit ____

Patient's Name (Last) ______________________________ (First) _________________________ (Middle Initial)______ Sex M / F

Street Address ____________________________________ City ___________________ State ________ Zip Code__________

Email Address __________________________________ SSN _____-_____-______ Date of Birth ____/____/____ Age ______

Marital Status ___________________ Texas Driver's License No. __________________________________

Home No. (____)_______________ Cell No. (____)________________ Work No. (____)________________

Occupation ______________________________ Place of Employment ____

How would you prefer to be contacted about upcoming or needed appointments? (Circle One) Email / Text Message / Phone

Who may we Thank for referring you? ____

Emergency Contact ___________________________ Phone No. (____)______________ Relationship__________________

PRIMARY PERSON RESPONSIBLE FOR ACCOUNT

Name (Last) __________________________________ (First)_________________________ (Middle Initial)______ Sex M / F

Street Address ____________________________________ City ___________________ State ________ Zip Code__________

Email Address __________________________________ SSN _____-_____-______ Date of Birth ____/____/____ Age ______

Marital Status ___________________ Texas Driver's License No. __________________________________

Occupation ______________________________ Place of Employment ____

PRIMARY DENTAL INSURANCE INFORMATION

Insured Name (Last) ________________________________ (First) ______________________________ (Middle Initial)________

Insured Date of Birth ______/______/______ SSN or Insurance ID Number ____

Insured Employer __________________________ Insurance Company ____

Insurance Group No.___________________________________ Insurance Phone No. (______)____________________

Insurance Address ____

SECONDARY DENTAL INSURANCE INFORMATION

Insured Name (Last) ________________________________ (First) ______________________________ (Middle Initial)________

Insured Date of Birth ______/______/______ SSN or Insurance ID Number ____

Insured Employer __________________________ Insurance Company ____

Insurance Group No.___________________________________ Insurance Phone No. (______)____________________

Insurance Address ____

We do not accept any Medicare, Medicaid, DMO, or HMO dental plans. Please provide appropriate Insurance information. Additional fees will be charged for re-filing insurance due to providing incorrect information. After 60 days you are responsible for any outstanding balance not paid by insurance.

____
Patient Initials

MEDICAL HISTORY

Please <u>circle</u> any conditions that you <u>presently have or have had</u>:

Heart Attack / Heart Disease / Heart Surgery / Heart Pacemaker / Heart Stints / Artificial Heart Valve

Blood Thinners / Angina / Chest Pain / Heart Murmur / Rheumatic Fever / Scarlet Fever / Stroke

Mitral Valve Proplapse / Congenital Heart Lesion / Congenital Heart Defect / High Blood Pressure

Low Blood Pressure / Arthritis / Back Problems / Neck Problems / Osteoporosis

Artificial Joint Replacement: Where? ______________________________ When? ______________________________

Do you **take or have you taken** Bisphosphonates (Actonel, Aredia, Boniva, Fosamax, Skelid, or Zometa)? Yes / No

Hepatitis: A / B / C Blood Transfusion? When? ____

Hemophilia (Bleeding Problems) / Bruise easily / Anemia / Leukemia / Shingles

A.I.D.S. / A.R.C. / HIV Positive / Venereal Disease / Herpes Complex / Breathing Problems

Emphysema / Asthma / COPD / Tuberculosis (TB) / Kidney Trouble / Liver Problems

Hypothyroid (Low) / Hyperthyroid (High) / Stomach Problems / Stomach ulcers / Diabetes

Fainting / Seizures / Epilepsy / Cancer / Tumors / Chemotherapy / X-ray or Cobalt treatment

Cosmetic Surgery: type________________________

Insulin / Hypoglycemia / Eye Problems / Glaucoma / Other: _________________________________

Psychiatric Problems / Nervousness / Currently taking Bipolar Medications / Hyperactive (ADHD)

Attention Deficit (ADD) / Developmental Delays (Autism/PDD)

Currently medicated for one of these? Yes / No

Seasonal Allergies / Hives / Food Allergies / Sinus Problems / Latex Allergy / Nitrous Oxide Allergy

Dental Anesthetics Allergy / Epinephrine Sensitivity / Penicillin Allergy / Codeine Allergy

Amoxicillin Allergy / Tetracycline Allergy / Aspirin Allergy / Iodine Allergy

Please list any allergies not provided above: ____

Are you currently under the care of a physician? Yes or No If yes, name of physician: _____________________

Are you currently pregnant? Yes or No If yes, how many weeks along? ________________________

Please list any medications you are currently taking: ____

____

Signature: ____ Date: ____

____

Staff Member Initials

DENTAL HISTORY

Date of: last dental visit ________________ Last Cleaning ________________ Last full mouth x-ray_______________

Do you have any dental problems now? If yes, please describe ____

____

Have you ever had an experience in a dental office that you would like the doctor to be aware of? If yes, please describe

____

Are your teeth sensitive to any of the following? Please circle

Hot Cold Sweets Biting Chewing

Any Mouth Odors? Yes / No Bad Tastes? Yes / No Do your gums bleed or hurt? Yes / No

Do you get cold sores, fever blisters, or oral lesions? Yes / No

Have your parents experienced gum disease? Yes / No

Have you noticed any loose teeth or change in bite? Yes / No

Does food tend to become caught in between your teeth? Yes / No

Please circle if you have had any of the following:

Orthodontic treatment / Oral Surgery / Periodontal treatment / Bite adjustment / Serious injury to mouth/head

If yes, please describe____

Have you ever experienced clicking or popping of the jaw? Yes / No If yes, please circle location: Left Right Both

Have you experienced pain in your: Jaw Joints Ear: Left / Right Side of Face

Do you have difficulty opening or closing your mouth? Yes / No

Please circle yes if you **have or have ever** experienced any of the following:

Clench or grinding teeth while awake or asleep? Yes / No Or have tired jaws, especially in the morning? Yes / No

Headaches, neck aches, or shoulder aches or sore muscles? Yes / No

Bite your cheeks or lips regularly? Yes / No

Past or presently smoke or chew tobacco? Yes / No

Difficulty chewing on either side of the mouth? Yes / No

Wear a bite guard or night guard Yes / No

Are you satisfied with your teeth's appearance? Yes / No

If you could change your teeth's appearance or smile, what would you change? ________________________________

____
Patient Initials

PATIENT AUTHORIZATION FORM

For the Dental Practice of:

Lindsay Dental Group, PLLC
22331 Gosling Road
Spring, Texas 77389

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed: Person or entity requesting the information and authorized to make the requested use or disclosure:

____

Recipient of the information: Dental Information, Insurance Companies, Specialist and/or family

____

This information is being requested for the following purpose(s):

____

____

____

____

This authorization shall remain in effect until I designate a specific date of termination:
___________ (expiration date or event)

I understand that:

1. I may inspect or copy the protected health information to be used or disclosed.
2. I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
3. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPPA.
4. I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

_____ If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: ____

Signature: ____ **Date**: _____________________

Relationship to Patient: ________________________________

(If signed by personal representative of Patient)

PATIENT CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

For the Dental Practice of: **Lindsay Dental Group, PLLC**

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ___________________________ Email: ____

Social Security Number: _______ - _______ - _____________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare 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 that you read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, 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 of Privacy Practices, including any revisions of our Notice, at any time by contacting the "Privacy Officer" at our office location on 22331 Gosling Road, Spring, Texas 77389 or phone (281) 586-0266.

Right to Refuse: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the "Privacy Officer" at our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

REVOCATION OF CONSENT: I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operators. I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: ____ Date: ______________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDEMENT

For the Dental Practice of:

Lindsay Dental Group, PLLC
22331 Gosling Road
Spring, Texas 77389

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: _________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ____________ Name: ______________________________________ Initials: ___________

Reason: ____