Doctors Paul Davis, Lauren Drennan (formerly Davis), and Dakota Davis
Our Family Caring for Yours

Patient Information

Patient's Name _____ Date_____/_____/_____
Last First Middle
Address_____
Street City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date___/___/____ Social Security # _____
Email Address _____ May we contact you by email? □Yes □ No
Employer _____ Occupation _____ # Years Employed_____
Responsible party's name: _____ Birth Date____/____/____
Relationship to patient _____ Occupation _____ Social Security # _____
Address_____
Street City State Zip
How did you hear about us? □Friend/Family _____ □Internet □Drive-by □Other: _____

Insurance Information

Insured's Name_____
Insured's Birth Date_____/_____/_____ Insured's Soc Sec # _____
Insurance Company _____ Group # _____ ID # _____
Insurance Co. Address _____Phone # _____

Spouse Information

Spouse's Name _____Relationship to Patient _____
Employer_____ Occupation_____No. Years Employed_____
Social Security # _____ Birth Date_____ Work Phone_____

Emergency Information

Name of nearest relative not living with you _____
Address_____
Street City State Zip
Contact phone # _____ Relationship _____

Visit our website DavisFamilyDentists.com for detailed information and videos of our procedures.

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Patient Name:_____

Medical History

Are you currently under the care of a physician? □Yes □ No Date of last physical: _____
Physican's name: _____ Phone # _____ Your physical health is: Good Fair Poor
Do you smoke or use tobacco in any form? □Yes □ No If yes, please explain:_____

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Hemophilia/Abnormal Bleeding
Y N Blood Transfusions
Y N Artificial Bones/Joints
Y N Arthritis
Y N Osteoporosis
Y N Heart Attack/Disease: if yes, when?_____
Y N Heart Surgery/Pacemaker: if yes, when?_____
Y N Artificial Valves
Y N Congenital Heart Defect/Murmur
Y N Mitral Valve Prolapse
Y N High Blood Pressure
Y N Low Blood Pressure
Y N Difficulty Breathing
Y N Asthma
Y N Emphysema
Y N Tuberculosis (TB): if yes, when?_____
Y N Chronic Bronchitis/COPD
Y N Sinus Problems
Y N Cancer/Radiation/Chemotherapy
Y N Depression/Anxiety
Y N Mental Disorders
Y N Epilepsy/Seizures/Fainting Spells
Y N Alcohol Dependency
Y N Drug Dependency: if yes, explain_____
Y N Insulin-Dependent Diabetes
Y N Type 2 Diabetes
Y N Glaucoma
Y N Fever Blisters/Herpes
Y N Hepatitis. Please circle which type: A B C
Y N HIV +/AIDS
Y N Shingles
Y N Kidney Problems
Y N Severe/Frequent Headaches
Y N Stroke/TIA
Y N Thyroid Problems
Y N Ulcers/Colitis
Y N Do you need premedication? Condition_____
Y N Hospitalized for Any Reason: explain_____

Have you ever taken a bone metabolism (**osteoporosis**) medication such as: Boniva, Fosamax, Zometa, Aredia, Actonel, etc.? If yes, please list which medication and how long: _____

Please list any **drugs/medications** that you are currently taking:

_____
_____
_____
_____

Are you **allergic** to any of the following?
Y N Aspirin
Y N Dental Anesthetics
Y N Latex
Y N Tetracycline
Y N Codeine
Y N Erythromycin
Y N Penicillin
Y N Sulfa or Sulfur Drugs
Y N Nickel
Y N Other
Please list any other drugs/medications that you are **allergic** to:

_____
_____
_____

For Women
Y N Are you pregnant or do you think you could be pregnant? Months: _____
Y N Are you nursing?
Y N Are you taking birth control prescriptions?

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Davis
Family Dental Care

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Dental History

General Dental

How can we help you today? _____
Is there anything about your mouth that concerns you now? _____
Do you experience discomfort when biting or chewing?_____
Do you experience sensitivity to hot or cold?_____
Do you have any old fillings or dental work that you do not like? _____
Do you still have your wisdom teeth? _____
Do you have any missing teeth? _____
When was the last time you visited the dentist? _____
When was the last time you had x-rays? _____

Your Dental Care Practices

How many times a day do you brush? _____ Floss?_____
What type of toothbrush do you use? (Circle one) Manual Electric Hard Medium Soft Other: _____
Do your gums bleed?_____ If yes, when? _____
Have you ever been diagnosed with gum disease, had gum treatment, or a deep cleaning? _____
Would you like us to coach you on home care? _____

Esthetics and Orthodontics

Are you pleased with the appearance of your teeth? If not, what do you not like? _____
Do you have any chipped teeth? _____
Are you happy with the color and shape of your teeth? _____
Have you ever had orthodontics?_____Are you pleased with the result? _____

Joint Symptoms

Do you experience popping, clicking, pain, or discomfort in your jaw joint area? _____
Do you wake up with a headache or jaw ache? _____
Are you aware of grinding or clenching? _____
Do you have a bite splint? _____ Do you wear it?_____
Has your bite been equilibrated? _____

Values and Expectations

What is/was the health of your parents' teeth?_____
Would you like to keep your teeth for a lifetime? Circle one: **Definitely want to Would be nice Only if it is affordable**
Do you have a high sugar or carbohydrate diet? _____
Any habits we should be aware of? Nail biting, toothpicks, mints or hard candy, other _____
Are you nervous about having dental treatment? _____
Is there anything we can do to make your visits more pleasant? _____

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I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
Please initial after reading each of the following:

— I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to Third Party Payor.

— I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

— **I understand that due to the restrictions placed by my insurance company on the level of benefits in the policy purchased by me/my employer, MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR THE SERVICES. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.**

— **All patients with Delta Dental Insurance must pay in FULL for treatment at the time of service and will be reimbursed by their insurance company.**

Signature (Parent or Guardian's signature if minor)_____

Printed Name_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Jim Moore - 469.342.8300, Extension 508

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses. We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limits.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, to the Texas Attorney General's Office, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Jim Moore, a Certified HIPAA Professional. You may contact our Privacy Officer in writing at our office address or by calling 469.342.8300, Extension 508. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on August 14, 2017.

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name

Witness Signature

Date Time

PATIENT UNDERSTANDING AND INFORMED CONSENT

EMERGENCY DENTAL CARE: Emergency dental treatment is intended to provide relief of severe pain and infection for individuals in acute need. You as a patient of record have access to a 24-hour dental emergency service. There is a charge associated with this service.

CONSENT TO DENTAL PROCEDURES: As a patient you will at all times have access to current and complete information about your condition and will, unless otherwise specified, receive continuity of treatment, be provided an estimate of the cost, and receive dental care according to a properly sequenced plan of treatment. Before receiving treatment you should ask the dentist or dental hygienist about the procedure(s) that he/she recommends you undergo, and ask any questions you may have before you decide whether or not to give your consent for the procedure(s) to be done. All dental procedures may involve risks of unsuccessful results and complications, and no guarantee is made as to result or cure. You have the right at all times to be informed of any such risks as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of no treatment. You have the right to consent to or refuse any proposed procedure at any time prior to its performance.

X RAYS: Dental radiographs will be made as necessary and appropriate for examinations, diagnosis, consultation, and treatment.

DENTAL MEDICAL RECORDS: Radiographs (x-rays), photographs, videos, models and other diagnostic aids relating to your treatment are the property of Dr. Davis. You have the right to inspect such materials and to request a copy of your dental records and radiographs. There is at least a $25.00 fee for copying these items. You may also request to have your dental radiographs sent to another health care provider by signing a Release of Information form.

KEEPING YOUR APPOINTMENTS: You are required to be on time for your appointments. If you find that you are unable to keep an appointment, you agree to notify our office at least 24 hours in advance. A total of two cancellations without 24-hour notice, two missed appointments, or repeated unsuccessful attempts to arrange an appointment may be cause to discontinue further treatment.

DISCONTINUANCE OF TREATMENT: We reserve the right to discontinue dental treatment whenever it is considered advisable and in the best interest of you.

Your signature on this form certifies that you have read and understand the information provided on the form, that you have received a copy, and that you accept dental care and treatment under the described terms and conditions.

Date:_____ Signature:_____

If signed by other than the patient, indicate relationship: parent or legal guardian:

_____