TOWN CENTER DENTAL
NEW PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____ Driver License Number: _____

Patient Name: _____ Date of Birth: _____ Age: _____
Last First Middle Initial

Sex: ○ M, ○ F ○ Social Security: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Material Status: ○ Single ○ Married ○ Widow ○ Divorced / Separated

E-Mail: _____ Best Contact Number: _____

Referral Source: _____ Type (Circle one): Cell / Home / Other: _____

DENTAL INSURANCE	SUBSCRIBER INFORMATION (If you are the subscriber, you may leave this part blank)	EMPLOYER INFORMATION (Skip this section if you are under 18)
Carrier:	Name:	Company Name:
Member ID:	DOB:	Phone:
Group #:	SSN:	Address:
Contact (800 #):	Relationship to Patient:	Occupation: (Optional)

DENTAL INSURANCE ASSIGNMENT AND RELEASE CONSENT:

I certify that I, and/or my dependent(s) have insurance coverage with _____
Name of Dental Insurance Carrier

And assign directly to Dr. Teresa Knott 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 paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my healthcare information and may disclose such information to above-named insurance company(ies) and their agents for the purposes 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 complete or one year from date signed below.

Signature: _____ Print Name: _____ Date: _____

PARTNER / SPOUSE INFORMATION	Please leave blank if: Single	Or if partner/spouse is the insured.
Name:	DOB:	SSN:
Best Contact #:	Employer:	Work #:

EMERGENCY CONTACT(S)	Best Contact Number	Relationship
Name:	Cell:	
Name:	Cell:	

DENTAL HISTORY	
Reason for today's visit:	
Former Dentist:	
City / State:	
Date of last dental visit:	
Date of last dental x-rays:	

TOWN CENTER DENTAL
NEW PATIENT REGISTRATION CONTINUED

PATIENT NAME: _____ DATE OF BIRTH: _____

DENTAL HISTORY QUESTIONNAIRE	PLEASE CIRCLE YES OR NO
How often do you brush in a 7-day period: _____	How often do you floss in a 7-day period: _____
Bad Breath	Yes / No
Bleeding Gums	Yes / No
Burning sensation on tongue	Yes / No
Chew on one side of mouth	Yes / No
Cigarette, pipe, or cigar smoking	Yes / No
Clicking or popping of jaw; pain or tiredness	Yes / No
Dry Mouth	Yes / No
Lip, cheek, or fingernail biting	Yes / No
Food collection between teeth	Yes / No
Grinding Teeth	Yes / No
Gums swollen or tender	Yes / No
Loose teeth or broken fillings	Yes / No
Mouth pain while brushing	Yes / No
Sensitivity to: Cold / Heat / Sweets / When biting	Yes / No
Blisters on lips or mouth	Yes / No
Sores or growths in / around mouth	Yes / No

Help us achieve your oral health goals!

O **Please answer the following questions:**

I. Do you like your smile? Yes / No

II. What do you NOT like about your smile?

_____

III. If you could change ONE thing about your smile, what would it be and why?

_____

IV. Why is it important to you to change your smile?

_____

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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ 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 ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ 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	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____

TOWN CENTER DENTAL FINANCIAL POLICY

PATIENT:_____DATE OF BIRTH_____

Thank you for choosing our office for your dental health care service. Please understand, that payment of your bill, is considered part of your treatment. We are confident our fees reflect the quality of care, that our services provide. However, we understand that people have different needs when fulfilling their financial obligations. Please read over our policy and sign at the bottom.

FINANCIAL POLICY

HALF of your estimated out of pocket portion, is required, when scheduling major restorative procedure. Ex: crowns/ bridges. Remaining portion due, on the date, services are rendered.

Payment in Full- Ask about our 5 % courtesy for payment in full **5** days, prior to your scheduled appointment. If you are Using dental insurance, 5% courtesy, on your estimated out of pocket portion. Payment method accepted for courtesy is **Cash or Cashier's Check Only.** This courtesy does not apply, if you participate, in the In House Dental Plan.

Pre-paid Payment Option- You are able to pay for your treatment in advance. Make payments, toward your total treatment estimate, weekly or monthly. Treatment will begin as soon as your credit balance equals the cost of your treatment.

Financing Options: We are able to offer you options that best suit your needs through **SUNBIT**. Fast approval and **No** hard credit check. We are happy to assist, in the process, in a few easy steps.

We accept: Visa, Master Card, Discover, American Express, Flex Spending cards and checks. For checks returned to our office, there is a $45 returned check fee. This is only to cover the processing fees, to us, by our banking establishment.

IMPORTANT DENTAL INSURANCE NOTICE

Our office accepts most PPO insurance policies. As a courtesy to you, we will file your insurance claim. Dental plans are intended to "assist" with the cost of treatment and do NOT cover all dental procedures. We are only able to estimate your percentage due for treatment based upon the information your insurance company provides. Your insurance provider states they "do not guarantee payment"!!! ANY balance remaining, after your insurance company has paid for your services rendered, is your responsibility and due within 30 days. If a claim is denied, our office will submit ONE appeal. If the appeal is denied again, you will be expected to cover the remaining balance. You will be asked, on occasion, to contact your insurance company to intercede, due to their lack of cooperation in paying your claim. Your coverage is as good as negotiated by your employer or purchased independently by you.

! ! ! IMPORTANT NOTICE ! ! !

*There will be a $50.00 charge for failed or cancelled appointments with our Hygienist and $100.00 with Dr. Knott. 48 hours, minimum, notice is required. Our office is closed on Monday's therefore messages left, on voice mail or by text are not retrieved, therefore does not allow us the opportunity to offer to another patient. We respect your time so please respect ours.

**Your appointment will be rescheduled if you are more than 15 minutes late or you failed to confirm.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party:_____Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication Consent Form

Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**
Patient Name:	**Date of Birth:**

This consent form allows Town Center Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Town Center Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Town Center Dental.

____ Initial I hereby authorize Town Center Dental to use *unsecured* email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; and, 2) Information related to billing and payment.

____ Initial I hereby authorize that Town Center Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ Email __ Home Phone __ Office Phone __ Cell Phone

____ Initial I hereby authorize that Town Center Dental may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

____ Initial I hereby authorize that Town Center Dental may disclose my personal health information to the person who I have listed as my emergency contact.

____ Initial I hereby authorize that Town Center Dental <u>may</u> disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

Furthermore, my (or my child's) personal health information **may NOT** be disclosed to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Town Center Dental services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Town Center Dental may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Town Center Dental is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

TOWN CENTER DENTAL
DR. TERESA KNOTT

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS:

The most common reason why we use or disclose your health information is for treatment, payment, or healthcare operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing/emailing them to be filled; referring you to another doctor or clinic for other healthcare or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Healthcare operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for healthcare operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting, investigation or surveillance and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for licensing of doctors, for adults by Medicare or Medicaid or for investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosures to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial or to organizations that handle organ or tissue donations.
- Uses or disclosures for health-related research.
- Uses and disclosures to prevent a serious threat to health and safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high-ranking government officials. For lawful national intelligence activities; for military purposes ; or for the evaluation and health of members of the foreign service.
- Disclosures of de-identified information
- Disclosures relating to workers compensation programs.
- Disclosures of a "limited data set" for research, public health, or healthcare operations.
- Incidental disclosures that are unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform healthcare operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments. Or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will make you an appointment reminder on a post card and/or leave you a reminder message on your home/cell phone or with someone who answers your phone if you are not available.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if its your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at anytime unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this. But if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.

4430 Lavon Dr. #370
Garland, TX 75040
(P) 972-530-5200
(F) 972-530-5377

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable and if you pay us any extra cost. If you want to ask for confidential communication, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site) You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of time for us to give you access or photocopies if wend you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send you the corrected information to the persons who we know got the wrong information, and other that you specify. If we do not agree, you can write a statement of your position and we will include it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. It you want to ask us to amend your health information, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want). By law, the list will not include disclosures of treatment, payment, or healthcare operations; disclosures with your authorization; incidental disclosures, disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent list, you will have to pay for them in advance. We will usually respond to your request withing 60 days of receiving it, but by law we can have a one 30-day extension of time for us to give you access or photocopies if wend you a written notice of the extension. If you want a list, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change it this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. It we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or e-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received / was offered a chance to read a copy of Town Center Dental Notice of Privacy Practices.

Patient Name (Print):_____

Signature: _____ Date: _____

4430 Lavon Dr. #370
Garland, TX 75040
(P) 972-530-5200
(F) 972-530-5377