Patient Information

Patient Name: _____ Preferred Name: _____ Gender: ___ Date: _____
Last First MI

Birth Date: _____ Family Status: _____ Social Security#: _____ Drivers License#: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell#: _____

Address: _____
Street Apt# City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street Apt# City State Zip Code

Whom may we thank for referring you to our practice? _____

Health Information

PLEASE LIST CURRENT MEDICATIONS YOU ARE TAKING: _____

_____

Date of your last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check YES or NO:

Y	N		Y	N		Y	N		Y	N	
❑	❑	AIDS	❑	❑	Excessive Bleeding	❑	❑	Hypoglycemia	❑	❑	Sinus Problems
❑	❑	Alzheimer's Disease	❑	❑	Excessive Thirst	❑	❑	Jaundice	❑	❑	Stomach Problems
❑	❑	Anemia	❑	❑	Fainting	❑	❑	Kidney Disease	❑	❑	Stroke
❑	❑	Arthritis	❑	❑	Fever Blisters	❑	❑	Liver Disease	❑	❑	Swelling of Feet/ Ankles or Hands
❑	❑	Artificial Joints/Hips	❑	❑	Frequent Cough	❑	❑	Lung Disease	❑	❑	Thyroid Disease
❑	❑	Artificial Heart Valve	❑	❑	Glaucoma	❑	❑	Mental Disorders	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Growths	❑	❑	Mitral Valve Prolapse	❑	❑	Tumors
❑	❑	Blood Disease	❑	❑	Have you ever taken Phen-Phen/Redux?	❑	❑	Nervous Disorders	❑	❑	Ulcers
❑	❑	Blood Transfusion	❑	❑	Hay Fever	❑	❑	Pacemaker	❑	❑	Venereal Disease
❑	❑	Bruise Easily	❑	❑	Head Injuries	❑	❑	Pain in Jaw Joints	❑	❑	X-Ray of Cobalt Treatment
❑	❑	Cancer	❑	❑	Heart Disease	❑	❑	Pregnancy Due Date: _____	❑	❑	Yellow Jaundice
❑	❑	Chemotherapy / Radiation	❑	❑	Heart Lesion	❑	❑	Psychiatric Care	❑	❑	Allergy: Penicillin
❑	❑	Chest Pain	❑	❑	Heart Trouble	❑	❑	Radiation Treatment	❑	❑	Allergy: Latex
❑	❑	Cold Sores	❑	❑	Heart Murmur	❑	❑	Recent Weight Loss	❑	❑	Allergy: Sulfa Drugs
❑	❑	Cortisone Medicine	❑	❑	Heart Surgery	❑	❑	Respiratory Problems	❑	❑	Allergy: Ibuprofen
❑	❑	Diabetes	❑	❑	Hemophilia	❑	❑	Rheumatic Fever	❑	❑	Allergy: Tetracycline
❑	❑	Dizziness	❑	❑	Hepatitis A / B	❑	❑	Rheumatism	❑	❑	Allergy: Aspirin
❑	❑	Drug Addiction	❑	❑	Herpes	❑	❑	Scarlet Fever	❑	❑	Allergy: Codeine
❑	❑	Emphysema	❑	❑	High Blood Pressure	❑	❑	Shortness of Breath	❑	❑	Allergy: Epinephrine
❑	❑	Epilepsy or Seizures	❑	❑	Low Blood Pressure	❑	❑	Sickle Cell Anemia	❑	❑	Allergies: _____

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

- Have you ever had any complications following dental treatment? ❑ Yes ❑ No If yes, please explain: _____
- Have you ever been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No If yes, please explain: _____
- Are you now under the care of a physician? ❑ Yes ❑ No If yes, please explain: _____
- **Name of Physician:** _____ **Phone:** _____
- Do you have any health problems that need further clarification? ❑ Yes ❑ No If yes, please explain: _____

In case of emergency, whom shall we call: Name: _____ **Relationship:** _____

Phone Numbers: _____

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, or if my medicines change, I will inform the doctors at the next appointment without fail.

X _____ Date: _____
Signature of Patient, Parent or Guardian

Reviewed by Dr: _____	Date: _____	Reviewed by Dr: _____	Date: _____
Reviewed by Dr: _____	Date: _____	Reviewed by Dr: _____	Date: _____
Reviewed by Dr: _____	Date: _____	Reviewed by Dr: _____	Date: _____

Responsible Party Information

Name: _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell#: _____

Address: _____
Street Apt# City State Zip Code

Insurance Information

Primary Insured Persons Information:

Name: _____ Birth Date: _____ ID or SS# _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name & Address: _____ Group#: _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Phone Number: _____

Secondary Insured Persons Information:

Name: _____ Birth Date: _____ ID# _____
Last First MI

Address: _____
Street City State Zip Code

Employer Name and Address: _____ Group#: _____

Patient's relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insurance Plan Name and Phone Number: _____

Consent for Services

As a condition of treatment by this office. I understand financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from my insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) (but no event more than the maximum rate permissible under the state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination in consideration of the professional services rendered to me, or at my request, by the Doctor and/or her staff. I agree to pay, therefore, the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

IT IS OUR POLICY TO CHARGE $15.00 PER 15 MINUTES FOR MISSED APPOINTMENTS WITHOUT 24 HOUR NOTICE. THIS FEE MUST BE PAID PRIOR TO SCHEDULING ANY FURTHER APPOINTMENTS.

I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their consent.

X _____ Date: _____
Signature of Responsible Party / Parent or Guardian

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims.

X _____ Date: _____
Signature of Responsible Party / Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Lannie E. Devin, DDS

X _____ Date: _____
Signature of Responsible Party / Parent or Guardian

Effective Date of this Notice: April 14, 2003

Lannie E. Devin, DDS
810 Frontage Road, Idalou, TX 79329
806-892-2557

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice understands that medical information about you and your health is personal and is committed to protecting this information. Lannie E. Devin, DDS will create a record of the care and services you receive. Lannie E. Devin, DDS needs this record:

- For planning your care and treatment;
- For communication among the health care professionals who contribute to your care;
- For verification by you or a third-party payer that services billed were actually provided;
- For an educational tool for health professionals;
- For a source of information for public health officials;
- To provide you with quality care and to comply with certain legal requirements.

This Notice will tell you about the ways in which Lannie E. Devin, DDS may use and disclose medical information about you. It also describes your rights and Lannie E. Devin, DDS's obligations regarding the use and disclosure of medical information.

By law, Lannie E. Devin, DDS is required to:

- Make every effort to keep private the medical information that identifies you;
- Give you this Notice regarding Lannie E. Devin, DDS's legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

The terms of this notice apply to all records containing your protected health information (PHI) that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment of this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Lannie E. Devin, DDS, 810 Frontage Road, Idalou, Texas 79329

C. WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your medical information. Although examples are provided where appropriate, it is impossible to list every use or disclosure in each category. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. **Treatment.** Our practice may use and disclose your medical information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with another physician. We will disclose PHI to other physicians who may be treating you. Also, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We will disclose PHI for pathology services. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your PHI in order to treat you or to assist others in your treatment. Unless clearly instructed in writing to the contrary, we may disclose medical information about you to those assisting in providing you care after you leave the office.
2. **Payment.** Our practice may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, Lannie E. Devin, DDS may need to disclose PHI to a health plan in order for the health plan to pay Lannie E. Devin, DDS for the services rendered to you. Lannie E. Devin, DDS may also tell your health plan about a treatment or procedure you are going to receive in order to obtain prior approval or to determine whether your plan will cover the services. We may give information about you to someone who helps to pay or pays for your care. If a balance remains outstanding after collection efforts from our office, we may give contact information to a collection agency for additional collection efforts.
3. **Health Care Operations.** Our practice may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office in an efficient manner and to ensure that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of health care services, and the appropriateness and quality of health care treatment. We may disclose information to doctors, nurses, technicians, medical students and staff members for review and learning purposes. Information may be disclosed for internal or external audits and to business associates for purposes of helping us to comply with legal requirements.
4. **Appointment Reminders.** Our practice may use and disclose your medical information to contact you and remind you of an appointment either in writing or by telephone. We also may use the information to contact you regarding follow-up care. Messages will be left on answering machines.
5. **Disclosures Required By Law.** Our practice will use and disclose your medical information when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your medical information:

1. **To Avert A Serious Threat to Health or Safety.** Our practice may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
2. **Health Oversight Activities.** Our practice may disclose medical information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** If you are involved in certain lawsuits or administrative disputes, our practice may disclose medical information about you in response to a court order or administrative order.
4. **Law Enforcement.** Lannie E. Devin, DDS may release medical information if asked to do so by a law enforcement official:

- In response to a court order or subpoena; or
- If the physician determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.

5. Research. Under certain circumstances, Lannie E. Devin, DDS may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the results of all patients who received one medication to those who received another medication for the same condition. All research projects are subject to a special approval process. Lannie E. Devin, DDS will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

6. Serious Threats to Health or Safety. Our practice may use and disclose your medical information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military and Veterans. If you are a member of the armed forces, Lannie E. Devin, DDS may release medical information about you as required by military command authorities.

8. Inmates. If you are an inmate of a correctional facility, Lannie E. Devin, DDS may release medical information about you to the correctional facility so that the facility can provide you with the treatment.

9. Public Health Risks. Lannie E. Devin, DDS may disclose medical information about you for public health activities.

E. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding the medical information that we collect and maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your medical matters in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the office manager for Lannie E. Devin, DDS. you do not need to give a reason for your request. Your request must specify how and where you wish to be contacted. Our practice will accommodate **reasonable** requests.

2. Requesting Restrictions. You have the right to request a restriction or limitation on the medical information our practice uses or discloses about your treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. **We are not required to agree to your request.** if we do agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment or otherwise required by law. In order to request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the medical information that may be used to make decisions about you, including patient medical records and billing records. you must submit your request in writing to the office manager for Lannie E. Devin, DDS in order to inspect and/or obtain a copy of your medical information. our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews. The person conducting the review will not be the person who denied your request. Lannie E. Devin, DDS will comply with the outcome of the review.

4. Amendment. You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office manager for Lannie E. Devin, DDS. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion:

(a) accurate and complete;
(b) not part of the medical information kept by or for the practice;
(c) not part of the PHI which you would be permitted to inspect and copy; or
(d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations. Use of your medical information as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the office manger for Lannie E. Devin, DDS. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the office.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with our practice, contact the office manager of Lannie E. Devin, DDS. The address for the Office for Civil Rights is:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SWY
Room 509F, HHH Building
Washington, DC 20201

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the office manager for Lannie E. Devin, DDS.

I have received the Notice of Privacy Practices for Lannie E. Devin, DDS

Signature & Date