Mann Dental Care

1111 Hwy 6 Suite 220 ° Sugar Land, TX 77478 ° (281) 494-9400

Patient Information

Last Name_____ First_____M_____Preferred_____

Sex Male / Female Martial Status_____Date of Birth____/_____/_____ SS#_____Driver's License #_____

Address_____City_____Zip_____E-mail_____

Phone Home ( )_____ Work ( )_____ Ext_____Best Time to Call_____

Number: Fax ( )_____ Pager ( )_____ Other ( )_____

Employer_____Address_____

In Case of Emergency_____Phone ( )_____Relationship_____

Name of Physician_____Phone ( )_____Hobbies/Interest_____

Responsible Party Information

☐ Check here if patient is responsible for the account, if ***not*** this section must be completed in full

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Last Name_____ First_____M_____Preferred_____

Sex ☐ Male ☐ Female Martial Status_____Date of Birth____/_____/_____Driver's License #_____Exp_____

Address_____City_____Zip_____E-mail_____

Phone Home ( )_____ Work ( )_____ Ext_____Best Time to Call_____

Referral Information

Whom may we thank for referring you to our practice?

☐ Drive By ☐ Yellow Pages ☐ Coupon ☐ Direct Mail ☐ Work ☐ Web Page

☐ Other_____☐ Family Member_____

Dental Insurance Information

Dental Insurance ☐ Yes ☐ No *If **yes** this section must be completed in full to have claims filed by our office

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

Subscriber's Last Name_____ First_____ Birth Date: _____/_____/_____

Subscriber's SS# / Badge# _____ Ins. Co_____ Phone_____

Subscriber's Employer Name_____ Address_____

Consent for Services

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

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

For your convenience, we will file your dental insurance claim after all deductibles and co-payments have been paid. I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance claim submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

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 content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient:_____

Dental Health Information

Date of Last Cleaning_____ Reason for Today's Visit_____

Check 3if you are aware of the following:

❑ Bad Breath	❑ Grinding Teeth	❑ Sensitivity to Hot	❑ Cold Sores
❑ Bleeding gums	❑ Loose Teeth	❑ Sensitivity to Cold	❑ Canker Sores
❑ Clicking or Popping Jaw	❑ Broken Fillings	❑ Sensitivity to Sweets	

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any gum problems or periodontal treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you have any teeth that bother you? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you smoke, chew or use tobacco? ☐ Yes ☐ No If yes, how often: _____
- Are you happy with the appearance of your teeth? ☐ Yes ☐ No
  If no, please explain: _____
- Have you ever been recommended to be Pre-Medicated before any dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you had any dental x-rays taken in the last 1-3 years? ☐ Yes ☐ No
  If yes, please explain: _____
- Former Dentist Name_____Phone Number_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Anemia/Leukemia	☐ Hay Fever	☐ Respiratory Problems	**Allergies**
☐ AIDS	☐ Head Injuries	☐ Rheumatic Fever	☐ Iodine Allergy
☐ Arthritis/Rheumatism	☐ Heart Disease	☐ Epilepsy/Seizures	☐ Sulfur Allergy
☐ Asthma	☐ Heart Murmur	☐ Scarlet Fever	☐ Latex Allergy
☐ Blood Disease	☐ Hepatitis	☐ Sinus Problems	☐ Penicillin Allergy
☐ Blood Transfusion	☐ High Blood Pressure	☐ Stomach Problems	☐ Codeine Allergy
☐ Cancer	☐ Jaundice	☐ Stroke	☐ Other_____
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis	**Women**
☐ Dizziness	☐ Liver Disease	☐ Tumors	☐ Pregnant Due Date____
☐ Excessive Bleeding	☐ Mental Disorders	☐ Ulcers	☐ Nursing/Lactating
☐ Fainting	☐ Nervous Disorders	☐ Growths	☐ On hormone therapy?
☐ Glaucoma	☐ Radiation Treatment	☐ Other_____	☐ Using oral contraceptives
☐ Artificial Joints/Prosthesis	☐ Pacemaker		

- Please list all medications you are currently taking_____
- Have you 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: _____

To the best of my knowledge, all of the answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Ofifice Use Only

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

MANN DENTAL CARE, P.A.

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 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 identifying 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 our 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.

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 or 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 or 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 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 or 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.

UESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 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.

COMPLAINT OFFICER
1111 Highway 6, Suite 220
Sugar Land, TX 77479
(281) 494-9400
FAX: (281) 494-9404

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
(Date}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

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 heath 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: _____

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FINANCIAL POLICIES

The following are the financial policies and guidelines for ***Mann Dental Care, P.A.*** Please read carefully before signing. Do not hesitate to ask any questions you may have.

Mann Dental Care, P.A. will be happy to submit insurance claims to your primary insurance company as a ***courtesy.*** The patient/guarantor is **responsible** for filing to their secondary insurance. **CO-PAYMENTS ARE DUE AT TIME OF SERVICE.**

Please be prepared to show your insurance card and driver's license at the time of your visit. If the patient has any insurance change, it is the patient's/guarantor's responsibility to provide the new information. If this information is not provided at the time of the visit, the patient/guarantor will then be responsible for the charges incurred.

Please be aware that some insurance companies may not cover all services performed in our office (e.g. routine preventive care, annual x-rays, etc.) The patient/guarantor is therefore responsible for charges denied by their insurance as a "non-covered benefit".

MISSED APPOINTMENT FEE OF $50 will be charged to any patient who does not notify our office within 48 hours to cancel/reschedule their appointment.

RETURN CHECK FEE OF $35 will be charged for any check returned for insufficient funds.

I authorize ***Mann Dental Care*** to file dental claims to my insurance and authorize release of all information necessary to process these claims. I authorize payment of my dental benefits to ***Mann Dental Care, P.A.*** I assume responsibility for payment of any balance on my account.

I have read and understood the above policies of ***Mann Dental Care, P.A.,*** and by signing below I agree to the above stated terms.

Signature _____ Date _____

Patient's Name (printed) _____