WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

1 Personal Information

Date _____

Birthdate _____

SS#/SIN _____ E-Mail _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Employer _____ Occupation _____

Referred by _____

2 Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS#/SIN _____ E-Mail _____

Address _____

City _____ State/ Prov. _____ Zip/ P.C. _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3 Telephone

Home Phone _____

Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Car

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4 Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS#/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS#/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

5 Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

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

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian if minor Date

6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card ____ Visa ____ MC

_____ I wish to discuss the dental office's policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask - we are always happy to help.

9156/051-1220

MEDICAL HISTORY FOR:_____(PRINT) _____(SIGN)

DATE:_____

Name of physician:_____

Phone Number of physician_____

Are you currently under the care of a physician? _____YES _____NO

If so, please explain _____

Do you use any forms of tobacco? _____YES _____NO

ALLERGIES TO MEDICATIONS? PLEASE CIRCLE

NO ALLERGIES	Latex
Aspirin	Penicillin
Barbiturates	Sedatives
Codeine	Sulfa Drugs
Dental Anesthetics	Tetracycline
Erythromycin	Other:_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

_____ YES _____NO

If so, please explain:_____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? PLEASE CIRCLE

Abnormal Bleeding	Blood Transfusion	Emphysema	Kidney Problem
Alcohol Abuse	Cancer	Epilepsy	Liver Disease
Anemia	Chemo/Rad	Heart Problems	Lupus
Artificial Joints/Bones	Colitis	High Blood Pressure	Mitral Valve
Asthma	Diabetic	HIV/AIDS	Stroke
Pacemaker	Psychiatric Problems	OTHER:_____	

STEPHEN W.BLAND,D.DS.
16815 Spring Creek Forest Dr.
Spring, Texas 77379
281) 370-2352

NOTICE OF PRIVACY

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of their insurance coverage.

OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We will only release information about you and your treatment under specific circumstances. These include, but not limited to the following:

TREATMENT: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers and our staff. Our staff includes full or part time employees as well as temporary personnel.

PAYMENT: We may disclose personal information about you and your treatment to third party and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies and third party administrators such as employee medical reimbursement accounts.

OPERATIONS: We may use your personal information in the course of operation of our office. This may include quality assurance/quality improvement reviews, credentialing, training and certification and accreditation activities.

MISCELLANEOUS USES: At certain times we require to use your information for other purposes than as described above. Examples of these uses include: appointment reminders, nation security, and in some cases to law enforcement and court ordered releases.

YOUR RIGHTS

RESTRICTIONS: You have the right to request on disclosure usage.

ACCESS: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule and appointment to view your information. You may also request a copy of your personal health information. We may/will charge a fee for the copies as set by the Texas State Board of Dental Examiners.

AMENDMENT: You have the right to amend your personal information and we will periodically request updates from you.

COMPLAINTS: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you can submit a written complaint to the United States Department of Health and Human Services. We can provide you with the address upon request.

_____ PLEASE INITIAL

STEPHEN W. BLAND, D.D.S.
16815 Spring Creek Forest Dr.
Spring, Texas 77379
281)370-2352

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

This authorization is required to release information not generally covered by our privacy notice. Authorization is required for any release not in connection with treatment, payment or operation of our dental practice.

I,_____, authorize the release of my personal health information to the following business or individuals:

FAMILY MEMBERS, INSURANCE COMPANIES, PHARMACIES, DENTAL SPECIALIST, SCHOOLS, PHYSICIANS.

_____

_____

_____

I authorize this release with full knowledge that this information can no longer be kept secure and private and that I release and indemnify the office of STEPHEN W. BLAND, D.D.S. and its employees from any harm or liability arising from release of said information.

This authorization is for the intended purpose of :
Releasing information to the above.

This authorization shall expire on December 31, 2020

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice. I also understand that I have the right not to sign this agreement.

NAME:_____

SIGNATURE:_____

RELATIONSHIP TO THE PATIENT:_____

DATE:_____

If we are unable to get your acknowledgement the office will make a notation as to the reason it was not obtained.

_____
_____
_____
_____

STAFF NAME:_____

SIGNATURE:_____

DATE:_____