Patient Information

Patient Name ____ ☐ Male ☐ Female Today's Date________________

Social Security #____________________ Birth Date_________________ ☐ Married ☐ Single ☐ Child ☐ Other _________

Phone (Home)____________________________ (Work)___________________________ (Cell)_______________________

Address____ Apt/Suite__________________

City____ State_____________________ Zip_________________________

Drivers License # _____________________________ Email Address____

Employer____ Occupation_________________________________

Employer Address____City________________State________Zip___________

Spouses Name____ Spouses Occupation____________________________

In Case of emergency, whom may we contact_____________________________________ Phone _____________________

Whom may we thank for referring you to our office?____

Spouse or Responsible Party Information

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

Name____ ☐ Male ☐ Female

Social Security #____________________ Birth Date_________________ ☐ Married ☐ Single ☐ Child ☐ Other _________

Phone (Home)____________________________ (Work)__________________________ (Cell)________________________

Address____ Apt/Suite_______________

City____ State_____________________ Zip__________________________

Insurance Information

Name of Insured___________________________________ Phone__________________ Is insured a patient? ☐ Yes ☐ No

Insured's Date of Birth________________________ ID#___________________________ Group #_______________________

Insured's Address____

Insured's Employer Name________________________________ Patient's relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Company Name_________________________________Address______________________________________

City__________________________ State__________ Zip____________ Phone #___________________

CONSENT: The undersigned hereby authorizes Doctor to take xrays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I grant the right to the Doctor to release health information obtained from me, and information about my dental treatment to third party payors, and/or health practitioners. I will authorize treatment only after all my questions have been answered to my satisfaction by the Doctor. Scheduling an appointment is interpreted as authorization to perform the treatment, medication, and therapy indicated. I understand that non-treatment of diagnosed problems can lead to tooth loss and other health problems, and that annual dental examinations are necessary to insure good dental health. I also understand the use of anesthetic agents may be necessary for some treatments and that these agents embody certain risks. Furthermore, I acknowledge that where appropriate, credit bureau reports may be obtained and an annual percentage rate of 12% will apply to unpaid balances over 60 days.

____________________________________ __________________ ______________________________

Patient Signature (or Parent/Guardian) **Date** **Doctor Signature**

Dental History

Reason for today's appointment?____

Date of Last Dental Visit____

Do you have any fears concerning dentistry?________________ What bothers you? __________________________________

How often do you brush your teeth? _________________________ Hard or soft toothbrush? __________________________

Do you use dental floss? _____________________ How often? ____

How long has it been since the last time your teeth were professionally cleaned? ___________________________________

In the past, about how often have you had dental check ups?____

Do you feel the condition of your parent's teeth has any effect on your dental future?________________________________

Do you feel that your teeth are in good, fair, or poor condition?____

To request prior dental records, what was the name of your last dentist?____

Have you ever had any negative experiences with any prior dental visits?____

If so, please explain. ____

Have you ever used nitrous oxide? ____

Have you had any complications during or following dental treatment? ____

If so, please explain. ____

Does food catch between your teeth? ____

Are any of your teeth sensitive to hot, cold, or pressure? ____

Do you have headaches? ____

Do you grind your teeth or clench your jaws? _________________________________Day, Night, or Both_________________

Do you have pain or popping in the jaw joint? _____________________________ Right Side, Left Side, or Both____________

Do you have sore or tight jaw muscles? ____

Do you chew on both sides of your mouth or do you favor one side? ____

Concerning your smile: Are you interested in improving the color, size, shape, spaces, or misalignment of your teeth?

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Please rank the following in order from 1 to 4 in which they would KEEP YOU FROM having dental treatment:

Fear of Pain _________ Lack of Concern __________ Cost of Treatment __________ Missing Work Time__________

Medical History

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

Name of Medical Doctor____ Phone ___________________________

Address ____

Date of Last Visit _____/____/_____ Reason for Last Visit ____

1. Are you currently under the care of a physician? _________ If yes, for what? _________________________________
2. Are you currently taking any medication, both prescription and non prescription? If yes, what medication and for what condition?____
3. Have you ever been told not to take Novocain? _______________ Have you ever had a local anesthetic? __________
4. Have you been admitted to a hospital or needed emergency care during the past two years? ____________________ If so, please explain: ____
5. Have you ever had a complication or reaction to dental anesthetics or following dental treatment? _______________ If so, please explain: ____
6. Have you ever had an allergic reaction to medication? ____________If yes, what medication and what type of reaction did you have? ____
7. Do you use tobacco or alcohol? ____________ If so, describe type and quantity________________________________
8. For women: Are you pregnant?____________ Are you taking hormones, including birth control?_________________
9. Have you had any surgeries, artificial joints replacements, or implants?________________________ If so, please explain. ____
10. Have you ever been told by your medical doctor that you need to premedicate? ______________________________

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

AIDS		Hay Fever		Rheumatism		Rheumatic Heart Disease	
Allergies		Head Injuries		Sinus Problems		Heart Attack	
Anemia		Heart Disease		Stomach Problems		Heart Surgery	
Arthritis		Heart Murmur		Stroke		Irregular Heart Beats	
Artificial Joints		Hepatitis (If so, which?)		Tuberculosis		STD/herpes simplex/cold sores	
Asthma		High Blood Pressure		Tumors		HIV positive	
Blood Disease		Jaundice		Ulcers		Serious Injury to head or neck	
Cancer		Kidney Disease		Venereal Disease		NSAID Allergy	
Diabetes		Liver Disease		Low Blood Pressure		Aspirin Allergy	
Dizziness		Mental Disorders		Aneurism		Codeine Allergy	
Epilepsy		Nervous Disorders		Mitral Valve Prolapse		Penicillin Allergy	
Excessive Bleeding		Pacemaker		Glaucoma		Erythromycin Allergy	
Fainting		Radiation Treatment		Breathing Problems		Cephalexin (Keflex) Allergy	
Glaucoma		Respiratory Problems		Chemotherapy		Clindamyacin Allergy	
Growths		Rheumatic Fever		Renal Dialysis		Other Allergy (explain below)	

Please explain anything you answered yes to above or any other health problems that need further clarification.

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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, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian ____Date___________________

Ellis Ramsey, DDS

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 copies, we will charge you $50.00 for each page, $50.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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.

QUESTIONS 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.

Contact Officer: Julie Coker

Telephone: 214-348-7090 Fax: 214-340-5259

E-mail: ellisramseydds@yahoo.com

Address: 9090 Skillman, Suite 267-A, Dallas, TX 75243

ELLIS RAMSEY, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

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