Smile Center

Today's Date:_____

Patient Information

Last Name: _____ First Name: _____ Middle Int : _____ DOB: _____

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

Home #: (____) _____ Work #: (____) _____ Cell #: (_____) _____

Email Address: _____ SS #: _____ DL #: _____ DL State: _____

Other Family Members Seen by Us: _____ Who may we THANK for referring you?: _____

Responsible Party Information

Last Name: _____ First Name: _____ Middle Int : _____ DOB: _____

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

Home #: (____) _____ Work #: (____) _____ Cell #: (_____) _____

Email Address: _____ SS #: _____ DL #: _____ DL State: _____

Relationship to Patient: _____ Employer: _____

Emergency Contact Information

Name of Contact: _____ Relationship to Patient: _____

Employer: _____ Contact #: (_____) _____

Primary Dental Insurance Info

Ins. Co. Name: _____

Company Phone #: (_____) _____

Ins. Co. Address: _____

Group/Policy#: _____

Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: _____

Insured's SSN/ID #: _____

Insured's Employer: _____

Secondary Dental Insurance Info

Ins. Co. Name: _____

Company Phone #: (_____) _____

Ins. Co. Address: _____

Group/Policy#: _____

Insured's Name: _____

Relationship to Patient: _____ Insured's DOB: _____

Insured's SSN/ID #: _____

Insured's Employer: _____

Dental History

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you currently in pain? ☐ YES ☐ NO If so, How Long? _____

Previous Dentist: _____

Dentist #: (____)_____ Last Visit: _____

Times a day do you brush? _____ Times a week do you floss? _____

Type of toothbrush bristles do you use? ☐ HARD ☐ MED ☐ SOFT

Is the Child's water fluoridated? ☐ YES ☐ NO

Do you require pre-medication? ☐ YES ☐ NO

Does Child require pre-medication? ☐ YES ☐ NO ☐ Don't Know

How would you rate your smile?

(Worst) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Best)

Please indicate ☑ any of the following problems:

- ☐ Locking jaw
- ☐ Teeth grinding
- ☐ Broken/Chipped tooth
- ☐ Ringing in ears
- ☐ Bad breath
- ☐ Blisters/Sores in/around the mouth
- ☐ Thumb/Finger Sucking
- ☐ Discomfort, clicking or popping jaw
- ☐ Lip Sucking/Biting
- ☐ Lost/broken Filling(s)
- ☐ Red, swollen or bleeding gums
- ☐ Stained Teeth
- ☐ Sensitive tooth, teeth or gums
- ☐ Tongue Thrusting/Sucking
- ☐ Heavy Snoring
- ☐ Mouth Breathing

Other:

_____

_____

_____

Smile Center

Today's Date:_____

Medical History

Physician Name: _____ Physician#: (_____) _____ Last Visit: _____

Are you currently under the care of a physician: ☐ YES ☐ NO If YES, explain: _____

Please indicate ☑ any of the following **medications you are taking:** ☐ Nerve pills ☐ Pain Killers (incl. Aspirin) ☐ Muscle relaxers ☐ Insulin

☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Meds for Osteoporosis ☐ Ritalin

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ YES ☐ NO Phen-fen/Redux ☐ YES ☐ NO

Please list all medications currently taking: _____

_____

_____

Please indicate ☑ any of the following **diseases, medical conditions or procedures you have or have had:**

☐ Heart Attack/Stroke	☐ Rheumatic Fever	☐ Heart Disease	☐ Hepatitis	☐ Scarlet Fever
☐ Thyroid Problems	☐ Respiratory Problems	☐ Psychiatric Problems	☐ Tuberculosis TB	☐ Diabetes/Hypoglycemia
☐ Cancer/Tumors	☐ HIV+/AIDS/ARC	☐ Emphysema	☐ Frequent Neck Pain	☐ Chemotherapy
☐ Cosmetic Surgery	☐ Asthma	☐ Leukemia/Anemia	☐ Bleeding Problems	☐ Cerebral Palsy
☐ Heart Surg./Pacemaker	☐ Mitral Valve Prolapse	☐ Congenital Heart Disease	☐ Nervousness	☐ Hearing Problems
☐ Kidney Problems	☐ Sinus Problems	☐ Venereal Disease	☐ Jaw Problems TMJ/TMD	☐ Hemophilia
☐ Shingles	☐ Arthritis/Rheumatism	☐ Fainting/Seizures/Epilepsy	☐ Back Problems	☐ Hyperactive/ADD
☐ X-ray or Cobalt Treatment	☐ Difficulty Breathing	☐ Chest Pains	☐ Glaucoma	☐ Artificial Bones/Joints
☐ Heart Murmur	☐ Artificial Heart Valves	☐ Alcohol/Drug Abuse	☐ High Blood Pressure	☐ Tonsillitis
☐ Liver Problems	☐ Stomach Issues/Ulcers	☐ Severe/Frequent Headaches	☐ Low Blood Pressure	☐ Cleft Lip/Palate

Please list any surgeries or medical conditions you have or ever had:

_____

_____

_____

Please indicate ☑ any of the following you are **Allergic** to: ☐ Latex ☐Penicillin/Amoxicillin ☐Dental Anesthetics ☐Tetracycline

☐Aspirin ☐Foods: _____ ☐Other: _____

Do you use tobacco products? ☐YES ☐NO If so, what product(s)? _____ How much? _____ If so, how long? _____

How would you rate your general health? (Worst) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (Best)

Do you wear contact lens? ☐ YES ☐ NO Blood type: _____

For Female Patients Only

Are you pregnant? ☐YES ☐NO If so, how long? _____ Currently nursing? ☐YES ☐NO

Currently taking birth control pills? ☐YES ☐NO

Please indicate ☑ to represent your understanding of the following:

❑ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

❑ Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

❑ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

❑ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature of parent/guardian Today's Date

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child need during treatment.

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.

Effective Date: April 14, 2003, Revised: September 23, 2013

We are committed to protect the privacy of your personal health information (PHI). This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.houmasmilecenter.com**

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We may use or disclose (share) your PHI to provide health care treatment for you.
Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician).

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.
EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:
If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law

Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information. Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.
Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services. Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.
We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:
Marketing
Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights
You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.
You have the right to see and obtain a copy of your protected health information.
This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.
You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.
We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request. **You may have the right to request an amendment of your health information.** You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights
You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have a right to receive notification of any breach of your protected health information.

Complaints
If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

OFFICE MANAGER AT (985) 868-7470

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003 and was revised on September 23, 2013.

If you have any questions about this Notice please contact the Privacy Officer.

Privacy Officer: **Dr. Bich Nguyen, DDS**
720 VERRET STREET HOUMA, LA 70360
PHONE: (985) 868-7470
FAX: (985) 868-4640
houmasmilecenter@gmail.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient's Last Name:_____ Patient's First Name: _____ DOB:_____

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

Telephone: (____) _____ Email: _____

Patient #: _____ Social Security #:_____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:	Dr. Bich Nguyen, DDS
Telephone Number:	985-868-7470
Fax Number:	985-868-4640
Email Address:	houmasmilecenter@gmail.com
Mailing Address:	720 Verret Street, Houma, LA 70360

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Information listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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 health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Last Name:_____ Personal Representative's First Name:_____

Relationship to patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date:_____