TECH RIDGE DENTAL

PATIENT INFORMATION

Name: _____
FIRST MI LAST

Preferred Name: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ ZIP: _____

SSN: _____ DOB: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ E-mail: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

Emergency Contact:

Name: _____ Phone: _____

Dental Insurance:

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Relationship to Patient: _____

Subscriber Employer: _____ Group Number: _____

Insurance Company Name: _____ Insurance Company Phone: _____

Assignment of Benefits and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all dental benefit payments to Tech Ridge Dental from my insurance company for the services rendered. I hereby authorize the office to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

I understand that if my insurance has a clause that will not allow assignment of benefits, full payment will be required at the time of service.

Patient/Guardian Signature: _____ Date: _____

TECH RIDGE DENTAL

MEDICAL HISTORY

Allergies: ☐ No allergies

☐ Codeine/Hydrocodone ☐ Penicillin ☐ Latex

☐ Others _____

Medications: ☐ No medications

_____

_____

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Abnormal Bleeding/Hemophilia	☐	☐	Glaucoma	☐	☐	Psychological Disorders
☐	☐	Active Asthma	☐	☐	HIV/AIDS	☐	☐	Radiation or Chemotherapy
☐	☐	Anemia	☐	☐	Heart Attack	☐	☐	Seizures
☐	☐	Angina Pectoris	☐	☐	Heart Surgery	☐	☐	Sinus Problems
☐	☐	Arthritis of the Hands	☐	☐	Hepatitis A , B , or C	☐	☐	Stomach Problems
☐	☐	Back Problems	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Infective Endocarditis	☐	☐	Thyroid Problems
☐	☐	Diabetes Type 1 or Type 2	☐	☐	Joint Replacement	☐	☐	Tobacco usage
☐	☐	Drug Abuse	☐	☐	Kidney Problems			
☐	☐	Emphysema	☐	☐	Liver Disease			
☐	☐	Epilepsy	☐	☐	Low Blood Pressure			
☐	☐	Fainting Spells	☐	☐	Osteoporosis			

FEMALES ONLY

☐	☐	Are you on Birth Control Pills?
☐	☐	Are you pregnant?
☐	☐	Are you nursing?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and I will inform this office of any changes in my medical status.

Print Name _____ Signature _____ Date _____

DENTAL HISTORY

How may we help you today? _____

Are you currently in pain? ☐ Yes ☐ No

Are your teeth sensitive to hot/cold or biting/chewing? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with previous dental visits? ☐ Yes ☐ No

Have you ever been diagnosed with periodonitis or gum disease? ☐ Yes ☐ No

Do you have any pain/discomfort in your jaw joint? (TMJ) ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

If "Yes" to any of the above, please explain: _____

Do you brush at least twice a day? ☐ Yes ☐ No Floss daily? ☐ Yes ☐ No

Date of last dental check up: _____ Date of last dental cleaning: _____

TECH RIDGE DENTAL

OFFICE POLICIES

Welcome and thank you for choosing us as your oral health care provider. Please read over the following information and indicate that you understand our office policies.

Consent: I authorize the evaluation and treatment by the doctors and staff at Tech Ridge Dental. I also give permission to take any necessary diagnostic processes (including, but not limited to, x-rays, photos, or study models) to enable complete diagnosis.

Appointments: A 2 business days notice is required when rescheduling or cancelling appointments. No shows, cancellations and reschedules less than 2 business days notice will be assessed a $35 broken appointment fee. Fees must be cleared to reserve any future appointments. Down payments are required to reserve longer appointments.

Payments: We accept VISA, Mastercard, Discover, debit cards, cash, and checks. In house payment plans may be available to assist with dental treatments. However, broken payment plans are assessed a $35 fee per month. Returned checks are also assessed a $35 fee, and no future checks can be received as payment.

If your account is sent to collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Dental Insurance: Our office is committed to helping you maximize your dental benefits, and as a courtesy, we will file dental claims for you. However, we do not file medical, medicaid, medicare, or DMO/HMO plans. Please understand that your dental benefit is an agreement between you and your insurance company. Insurance companies do not always share with us the intricacies and exclusions of your plan, so we can only give you an estimate. Therefore, if your insurance company pays less than the estimate or if for any reason denies payment on the claim, you are still responsible for the remaining balance.

If your dental insurance does not allow assignment of benefits, full payment will be required at the time of service.

By signing below, I acknowledge and accept the office policies of Tech Ridge Dental.

Print Name	Signature	Date

TECH RIDGE DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

TECH RIDGE DENTAL

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 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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.

Restrictions: 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:	Kenneth Ma
Telephone:	512-821-2394
Fax:	877-681-3027
E-Mail:	ken@techridgedental.com
Address:	12400 N. IH-35, Suite A131
	Austin, TX 78753