PATIENT INFORMATION

This information is necessary for our files and will be considered confidential

Today's Date _____

Patient's Last Name _____ First Name _____Middle _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security # _____

Texas Driver's License # _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____

Place of employment _____ City _____ State _____

Emergency Contact and Phone # _____ _____

Whom may we thank for referring you to us? _____

FINANCIAL INFORMATION

Name of party responsible for this account _____ Date of Birth _____

Relationship _____ Email _____

Home Phone # _____ Cell Phone # _____

Social Security # _____ Driver's License # _____

Work Phone _____

FOR YOUR INFORMATION

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also understand and agree that any and all past due balances over 30 days will be subject to a 1.5% finance charge per month.

X _____ _____ _____

Signature of responsible party Relationship Date

PAYMENT POLICY

Dental Insurance Patients: Patient co-pay and any deductible are due at time services are rendered.
Non-Insurance Patients: Payment in full is due at time services are rendered.

Payment options (Please check how you will be paying today)
_____ Check
_____ Cash
_____ Credit Card (we accept MasterCard, Visa, Discover Card)
_____ Care Credit: A unique credit card designed to make dental bills more affordable.

ASSIGNMENT OF INSURANCE BENEFITS

Dental Insurance Company:_____ Group #_____

In consideration of services rendered, I hereby transfer and assign to John B. Struble, D.D.S, all right title and interest in any payment due me for services as provided in the policy or policies of insurance held by me. I agree to pay John B. Struble, D.D.S. at 209 Canyon Court, Willow Park, TX 76087 all charges held by me. I further agree and authorize John B. Struble, D.D.S. to release any information requested by the insurance company(s) or its representatives.

_____ _____

Policy Holder / or Authorized Agent Date

Health Questionnaire

_____ _____ _____

Name of Physician Phone number Date of Last Physical

Please CIRCLE any of the following, if you have ever had:

Heart Problems	Glaucoma	Chronic Sinus
Heart Murmur	Diabetes	Ear Problems
Mitral Valve Prolapse	Arthritis	TMJ or Jaw Joint Pain
Heart Valve Replacement	Anxiety Problems	Asthma
Rheumatic Fever	Gastrointestinal Problems	Tuberculosis
High Blood Pressure	Kidney Problems	Venereal Disease
Low Blood Pressure	Liver Problems	Herpes
Circulatory Problems	Smoking/Dipping History	Fever Blisters
Excessive Bleeding	Cancer/Malignancies	Osteoporosis
Anemia	Joint Replacement	Epilepsy
Stroke	AIDS	Fibromyalgia
Pacemaker	Hepatitis	Head Injury

Women: Are you or could you be pregnant? _____ If yes, how many months? _____

Please CIRCLE any and all that you are ALLERGIC to:

Penicillin LATEX Aspirin Codeine Local Anesthetic Other:_____

Please list all medications that you are currently taking: (or provide us with a list)

_____

Dental Health Information

Who is your General Dentist? _____

Please CIRCLE YES (Y) or NO (N)

Are you having pain at this time?	Yes	No
Have you had an injury to your mouth?	Yes	No
Have you ever had a “root canal” procedure?	Yes	No
Have you ever had a “root canal” that failed?	Yes	No
Do you have sensitivity to HOT?	Yes	No
Do you have sensitivity to COLD?	Yes	No
Do you have swelling in your gums?	Yes	No
Do you have PAIN in your jaw joint, ear or face?	Yes	No
Do you have difficulty opening your mouth?	Yes	No
Does it hurt to chew or bite?	Yes	No
Do you clench or grind your teeth?	Yes	No
Are you nervous about dental treatment?	Yes	No

X_____ _____ _____

Signature of Responsible Party Relationship Date

Notice of Privacy Practices

John B. Struble, D.D.S

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

This Notice of Privacy Practices describes how we may use and disclose your protected health on information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protection health information. We are required by Federal law to give you this **Notice** and to maintain the privacy of practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

How We May Use and Disclose Your Protected Health Information

You will be asked to sign an **Acknowledgement of Receipt of Notice of Privacy Practices** when we give you our **Notice of Privacy Practices**. Once you have received our **Notice**, we will use your protected health information for treatment, payment and health care operations. Your protected health information may be used and disclosed by 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. Your protected health information may also be used and disclosed to pay your health care bills and to support the operations of our practice. Following are examples of the types of uses and disclosures of your protected health information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentist and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom, you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payments: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when the doctor is ready to see you. We may use or disclose your protected health information to contact you to remind you or your appointment. We may also use your name to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for our practice. Whenever we disclose protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information.

Your Written Authorization is Required For Other Uses of Your Protected Health Information

Other uses and disclosures of your protected health information will be made only with written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our practice has already released your health information as provided for in your authorization.

How We Will Use Your Health Information With Your Authorization of Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part of your protected health information. If you are not present or able to agree or object (such as in an emergency) to the use or disclose of the protected information, then we may use professional judgment and common practice to determine whether the disclosure is in your best interest. In this case, only the protected health information that is needed to provide your health care will be disclosed.

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will

also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

Other Disclosures That May be Made Without Your Consent

Required By Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgment of Receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose your health information using our professional judgment, disclosing only health information that is necessary to provide your health care.

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 our health information to the extent necessary to avert a serious threat or safety or the health and safety of others.

Military Personnel and National Security: We may disclose the health information of Armed Forces personnel when requested by command military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other information of inmates under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliances.

You Have the Following Rights

Inspect and copy your protected health information. 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 practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending a letter using the contact information listed at the end of this notice. We will charge you a reasonably cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
Request a restriction of your protected health information: 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.

Request alternative communications: You have a 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.

Request an amendment to your health information: You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

Receiving an accounting of disclosures we have made of your information: You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee.

Make a complaint about our privacy practices: If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with your Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint or charge the way we treat you.

To obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: 5-01-11

Privacy Officer: John B. Struble, D.D.S
209 Canyon Court, Willow Park, TX 76087 **Telephone: 817-441-1211**

Acknowledge of Receipt
Of
Notice of Privacy Practices

I, _____have received a copy of
(Name of Patient/Please Print)

John B. Struble, D.D.S. Notice of Privacy Practices.

_____
(Signature of Patient)

Staff will fill out this section if signature is not obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could be obtained forth following reasons:

_____Patient refused to sign.
_____Emergency situation kept us from obtaining the patient's signature.
_____Language barriers kept us from obtaining the patient's signature.
_____Other:_____

_____
Staff Signature: