Patient Information

Patient Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City, State, Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

E-Mail:_____

Marital Status: ____ Minor ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Emergency Contact Name: _____ Emergency Contact Phone: _____

Whom may we thank for referring you to our practice? _____

Responsible Party Information

Who is responsible for payment of this account: ____ self ____ spouse ____ parent/guardian ____ other

Fill out the below information if the responsible party is someone other than self:

Responsible Party Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City, State, Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

E-Mail:_____

Insurance Information

Insurance Name: _____ Insurance Phone: _____

Street Address: _____

City, State, Zip: _____

Member ID: _____ Group Number: _____

Who is the policy holder: ____ self ____ spouse ____ parent/guardian ____ other

Fill out the below information if the policy holder is someone other than self:

Name of Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Social Security #: _____

Health Information

Name of Previous Dentist: _____ Date of Last Dental Visit: _____

Reason for this visit: _____

_____

Name of Primary Care Physician: _____ Phone: _____

Physician Address: _____

Name of Pharmacy: _____ Phone: _____

Pharmacy Address: _____

MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY:

□ Allergies:

_____

_____

_____

□ Allergic/Adverse Reaction to Medication or Any Substance:

_____

_____

_____

□ AIDS
□ Anemia
□ Arthritis
□ Artificial Joints
□ Artificial/Leaky Heart Valve
□ Asthma
□ Blood Disease
□ Bruise Easily
□ Cancer
□ Cold Sores/Fever Blisters
□ Contact Lenses
□ Cortisone Medication
□ Diabetes
□ Diet (Special/Restricted)
□ Dizziness
□ Emphysema
□ Epilepsy
□ Excessive Bleeding
□ Fainting
□ Glaucoma
□ Growths
□ Hay Fever
□ H.I.V. Positive
□ Head Injuries
□ Heart Attack/Disease/Surgery
□ Heart Murmur
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ Jaundice
□ Kidney Disease
□ Latex Sensitivity
□ Liver Disease
□ Mental Disorders
□ Mitral Valve Prolapse
□ Nervous Disorders
□ Pacemaker
□ Psychiatric/Psychological Care
□ Pregnancy:
Due date: _____
□ Radiation Treatment
□ Respiratory Problems
□ Rheumatic Fever
□ Rheumatism
□ Sinus Problems
□ Smoke/Chew Tobacco
□ Stomach Problems
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Tumors
□ Ulcers
□ Venereal Disease
□ Do you pre-medicate with antibiotics prior to dental visits?
_____ Yes _____ No

Are you currently taking any medications? ____ Yes ____ No

If yes, please list: _____

_____

Have you been admitted to a hospital or needed emergency care during the past two years? ____ Yes ____ No

If yes, please explain: _____

_____

Are you currently under the care of a physician? ____ Yes ____ No

If yes, please explain: _____

_____

To the best of my knowledge, all of the proceeding answers and information provided are true and correct.

If I ever have any change in my health, I will inform the doctor at my next appointment without fail.

Signature of patient/guardian: _____ Date: _____

PATIENT NAME (PRINT):_____ DOB:_____

CANCELLATION/NO SHOW POLICY

Cancellation of Appointments

I agree to keep all scheduled appointments unless I notify the office at least 24 hours prior to my appointment time. I understand that failure to keep a scheduled/confirmed appointment may result in a missed appointment fee of $50.

Signature of patient/guardian: _____ Date: _____

SHARE DENTISTRY PLLC
INSURANCE POLICY

1. Full payment or co-payment is due at the time of service. We offer an extended payment plan with prior approval.

2. We are happy to file to your primary insurance for your treatment. However, the balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may not be considered reasonable and necessary under your dental coverage.

3. Regarding insurance plans in which we are a participating provider: All payments and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan in which we are not participating providers, refer to the above paragraph.

4. Collection policy: In the event that you have missed a payment, a letter will be sent first. If your account is not brought current within two months, active treatment will be suspended. If your account becomes 90 days past due, treatment will be discontinued and your account will be sent to an automated collection service. If this occurs, your account will be reviewed for immediate collection procedures and a service charge may be added to the account.

5. I authorize the release of my dental information to all of my insurance companies.

6. I authorize the release of my dental information for all of my insurance submissions.

7. I authorize the payment of dental benefits to Dr. Milton Dang, DMD.

Print Patient Name: _____

Signature of patient/guardian: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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. Please ask a staff member for a copy of our Notice of Privacy Practices. We encourage you to read it carefully and completely before signing this Consent. Our Notice of Privacy Practices 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. 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:

Share Dentistry
2100 W. Northwest Highway, Suite 204
Grapevine, TX 76051
817-329-6000

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 Person 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.

Print Patient Name: _____

Signature of patient/guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, the patient, have received a copy of Share Dentistry's Notice of Privacy Practices.

Print Patient Name: _____

Signature of patient/guardian: _____ 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)

_____

_____

_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby authorize Share Dentistry to release my patient health information as described below:

Person(s) to Disclose to		Type of Info to Disclose (one or both)		Method of Disclosure (one or both)	
Name	**Relationship**	**Medical**	**Billing**	**By Phone**	**In Person**

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.
HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of Share Dentistry. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, Share Dentistry will not be able to release any information, including appointment or patient billing questions, to anyone other than the patient.
I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), govern the terms of this Authorization. I understand that I have the right to revoke this Authorization at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I understand that any revocation must include my name, address, telephone number, date of this Authorization, and my signature.

(Check One) I DO____DO NOT____ GIVE PERMISSION to Share Dentistry to leave information on my answering machine in regards to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members.

Print Patient Name: _____

Signature of patient/guardian: _____ Date: _____