BLVD
DENTISTRY &
ORTHODONTICS

NEW PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Ok to receive email correspondence? (Appt reminders, etc): YES / NO

How did you hear about BLVD Dentistry? _____

Social Security: _____ D.O.B: _____ DL#: _____

Emergency Contact: _____ Phone: _____

Sex: M or F Marital Status: Single Married Divorced Separated Widowed Partnered

Please carefully read below:

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE BLVD DENTISTRY TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND BLVD DENTISTRY, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO BLVD DENTISTRY AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (“HIPAA”).

_____ _____

Patient Signature Date

BLVD DENTISTRY & ORTHODONTICS

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain _____

Are you taking any medications, pills or drugs? Yes No If yes, please explain _____

Do you take or have you taken Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Women:
Taking oral contraceptives? Yes No
Pregnant/Trying to get pregnant? Yes No
Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other _____

Do you have or have you had any of the following?

AIDS/HIV Positive
Alzheimer's disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problem
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Disease
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease
Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No If yes, please explain _____

Additional Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

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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.

BLVD Dentistry & Orthodontics is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of BLVD Dentistry & Orthodontics and will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
- Bill for services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
- Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share health information for certain situations, such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
- Comply with law. We can share information about you if state or federal law requires is, including the Department of Health and Human Services.
- Do Research. We can use and share information for health research.
- Family and Friends. We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
- Organ and tissue donation requests. We can share information about you to organ procurement organizations
- Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security)
- Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights, we typically use or share your health information in the following ways:

- Get an electronic or paper copy of your medical information. You have the right to inspect and/or obtain a copy of your medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) of your medical information, we may charge you a reasonable, cost-based fee.
- Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
- Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no.
- Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.
- Privacy Notice. You can ask and receive a paper copy of this notice at any time.
- Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases we will never share your information unless given written permission: Marketing purposes, fundraising, and the sale of information.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have
compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice of Privacy Practices.

We will not share your information other than described in here unless we receive written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Thomas Southam by mail at: 107 Yale St, Suite 300, Houston, TX, 77007 or telephone at 832-900-2071. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person(s):
Please note the names of all people you authorize, along with their relationship to you (spouse, parent, etc.)

_____

_____

_____

I have read and understand the above information.

_____ _____
First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Today's Date

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For office use only

The following patient/authorized representative _____

☐ Refused to sign the Notice of Privacy Practices because _____

☐ Was unable to sign the Notice of Privacy Practices because _____

Date: _____

Signature: _____

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BILLING PROCESS

Thank you for choosing BLVD Dentistry. In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with your dental insurance, we call your insurance company and verify your benefits. The information we receive from your insurance company is **only an estimation** of coverage and **not a guarantee.** After you have been seen in our office, we will file your claim to the insurance company directly. If the insurance company does not cover the estimated amount in full, you will receive a statement in the mail and be responsible for the remaining account balance.

Thank you again for choosing BLVD Dentistry for your dental needs. We look forward to a long relationship with you.

I have read and understand the billing process at BLVD Dentistry.

_____	_____	_____
Patient's Name (Printed)	Patient's Signature	Date

PRACTICE POLICIES

Our goal is to provide quality dental care in a timely manner. In order to do so, we have implemented a cancellation and no show policy. The policy enables us to better utilize available appointments for all of our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you make an attempt to call at least 24 hours in advance.

NO SHOW POLICY

A "no show" is an appointment that was not canceled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of $50 for every half hour scheduled.

LATE ARRIVALS

In an effort to serve our patients in a timely manner, we ask that you arrive on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

CELL PHONE POLICY

As a courtesy to other patients and in an effort to maintain our schedule, we request that cell phones be put away while the doctor, hygienist or assistant is in the room with you.

I have read and understand the "Practice Policies".

_____	_____	_____
Patient's Name (Printed)	Patient's Signature	Date