Spring Dentist

PATIENT REGISTRATION

First Name:_____ Middle Name:_____ Last Name:_____

Sex: **Male** **Female** DOB:_____ Marital Status: **Single** **Married** **Divorced** **Separated** **Widowed**

SS# (required):_____-_____-_____ Driver's License #:_____

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

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: _____-_____-_____

E-Mail:_____

Contact Preference: ☐ **E-Mail** ☐ **Cell** ☐ **Work** ☐ **Home** ☐ **Text** **Best Contact Time:** ☐ **AM** ☐ **PM**

Occupation:_____ Employer:_____

IN CASE OF EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone #: _____-_____-_____

PRIMARY DENTAL INSURANCE: (If any SECONDARY INSURANCE, it must be filed by the patient)

Policy Holder:_____ DOB: _____ SS#:_____-_____-_____

ID#:_____ Group #:_____ Employer:_____

Insurance Company_____ Insurance Phone #: _____-_____-_____

DENTAL HISTORY

Previous Dentist:_____ Phone #:_____-_____-_____ Last Dental Visit:_____ New Patient: **Y or N**

How often do you Floss:_____ Brush:_____ Do you want whiter teeth? _____

Are you happy with your smile? If no, explain _____

Reason for today's visit: _____

PLEASE CHECK ANY THAT APPLY:

☐ Are you apprehensive about dental treatment	☐ Wear Dentures	☐ Sensitivity to hot or cold	☐ Stained teeth
☐ Discomfort, Clicking, Locking or Popping in jaw	☐ Lost or Broken Fillings	☐ Sensitivity to sweets	☐ Speech problems
☐ Blisters/Cold Sores in or around the mouth	☐ Habitual Gum Chewer	☐ Gag Easily	☐ Ringing ears
☐ Finger/Thumb Sucking	☐ Loose teeth or change in bite	☐ Trap food between teeth	☐ Tobacco Habit
☐ Red, swollen or bleeding gums	☐ Pain (in joint, ear, side of face)	☐ Teeth grinding/clenching	☐ Headaches

Other:_____

HOW DID YOU HEAR ABOUT US?

☐ Office Website ☐ Internet ☐ Facebook ☐ Drive By ☐ Referral If referral, who? _____

NO SHOW AND CANCELLATION FEES

When we make your appointment, we prepare your records and reserve time for your particular needs. We ask that if you must change an appointment, please give us at least 48 BUSINESS hours notice. This courtesy makes it possible to give your reserved time to another patient who would like it. We reserve the right to reschedule your appointment time if you are more than 15 minutes late. It is your responsibility to notify us of any change in your contact information.

There is a $50 charge for not showing up to your scheduled appointment and for any cancellations made less than 48 BUSINESS hours prior to your appointment.

Repeated cancellations, reschedule, or missed appointments will result in loss of future appointment privileges.

MEDICAL HISTORY

Physician's Name _____

Phone: _____ - _____ - _____ Date of last visit: _____

Are you currently under physician care? **Y N**

If yes, describe _____

Have you ever had any serious illnesses or operations? **Y N**

If yes, describe _____

Have you ever had a blood transfusion? **Y N**

If yes, give approximate date _____

WOMEN ONLY:

Pregnant? **Y N** Nursing? **Y N** Taking birth control or other hormones? **Y N**

Medications:

Are you taking blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginko, Biloba, Aggrenox, Pradaxa, Fish Oil)? **Y N**

Are you taking, or have you ever taken, bone density meds, bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, or Aredia in the past 12 years? **Y N**

List any other medications:_____

_____

_____

_____

ARE YOU ALLERGIC TO: (please circle)

Anesthetics Penicillin Sulfa drugs Aspirin Amoxicillin Narcotics Latex Erythromycin Tetracycline Acetaminophen Ibuprofen

Other: _____

CHECK ALL THAT APPLY:

___AIDS/HIV Positive	___Circulatory Problems	___History of drug abuse	___Rheumatic/Scarlet fever
___Anaphylaxis	___Diabetes	___Kidney Disease	___Shingles
___Anemia	___Epilepsy	___Liver Disease	___Shortness of breath
___Arthritis/Rheumatism	___Fainting	___Mitral valve prolapse	___Stroke
___Artificial Heart Valves	___Glaucoma	___Nervous problems	___Surgical implant
___Artificial joints/bones	___Heart Murmur	___Pacemaker/Heart Surgery	___Thyroid disease
___Asthma	___Hemophilia	___Psychiatric care	___Tobacco habit
___Atopic (allergy prone)	___Herpes	___Rapid weight gain/loss	___Tonsillitis
___Blood disease	___Hepatitis; Type ____	___Radiation treatment	___Tuberculosis
___Cancer	___High Blood Pressure	___Removable dental appliance	___Ulcer/Colitis
___Chemical Dependency	___History of alcohol abuse	___Respiratory disease	___Veneral disease

UPDATES

_____ Initials	___/___/___ Date
_____ Initials	___/___/___ Date
_____ Initials	___/___/___ Date
_____ Initials	___/___/___ Date
_____ Initials	___/___/___ Date

PHARMACY INFORMATION:

Name:_____ Phone #:_____-_____-_____

Do you Require Pre-Medication: ☐ **Yes** ☐ **No** ☐ **Don't Know**

Our policy requires payment in full for all services rendered at the 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. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.**

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 certify that I have read and understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to the best of my knowledge. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

I **acknowledge** that I have received the "Notice of Privacy Practices" of Joshua Kuykendall DDS, PLLC. By signing this form, I consent to the use and disclosure of myself and my minor dependents protected health information to carry out treatment, payment activities, and healthcare operations.

Signature_____ **Date**_____/_____/_____

Spring Dentist

Joshua Kuykendall, DDS PLLC

Office and Financial Policies

Check-in: Be prepared to update any and all paperwork needed. Please notify us of any changes to your insurance and contact information at time of check in. Please don't forget to give us your e-mail address or cell phone number if this is the best way to contact you. We use an automated service that sends out text and e-mail reminders and confirmation requests. This makes it more convenient for those that cannot answer phone calls at work.

Check- out: Please be prepared to cover any expenses for the current visit as well any outstanding balances, co-payments or fees not covered by your insurance provider. For your convenience we accept cash, personal checks, money orders, debit and credit cards (Visa, Mastercard, Discover, AMEX), flex spending, and Care Credit.

No Shows/Late Arrivals: Our schedule is very important. In order to maintain a functional day, we reserve the right to cancel/reschedule your appointment if you arrive more than 15 minutes late. We require **AT LEAST 24 HOURS** advance notice if you must cancel/reschedule your appointment in order to avoid a **$50** charge. For your convenience, multiple reminders are sent out via our automated system and phone call attempts are made by the staff, which is why it is very important to always have your contact information up to date.

Treatment Plans: Any treatment plan given detailing your out of pocket expense is only an estimate and any not be accurate until final payment is received from insurance. Treatment is subject to change as indicated.

Insurance: For your convenience and as a courtesy, we will gladly file your insurance claim to the insurance for services rendered at your visit. However, if there is secondary insurance, it is your responsibility to file the claim. We will provide you with the necessary documentation. We allow 60 days from treatment for your insurance to make a payment. After the 60 days, the patient is responsible for the entire balance. If by 90 days the account has not been paid, collection proceedings will begin. It is your responsibility to follow up on the status of all claims. Ultimately, you are responsible for any balances.

Un-insured Patients: We ask that payment be made at time of service for those patients without insurance unless other payment arrangements have been made. We do offer a 5% discount for cash or check payments only.

Minors: If for any reason a minor cannot be accompanied by an adult we will need to be notified in advance in order to have consent forms signed. Unaccompanied minors must have full payment at the time of their visit unless payment arrangements have been made.

Divorced Parents: We do not get involved in family affairs; therefore, it is the responsibility of the parent accompanying the patient to provide current insurance information along with any payment at the time of service.

I acknowledge that I have received the "Notice of Privacy Practices" of Spring Dentist - Joshua Kuykendall DDS, PLLC. By signing this form, I consent to the use and disclosure of myself and my minor dependents protected health information to carry out treatment, payment activities, and healthcare operations.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information. I authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name (printed) _____

Signature of Responsible Party _____ Date_____

Spring Dentist

Joshua Kuykendall, DDS PLLC

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. THE PRIVACE OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information ('PHI'). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We are required to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect until we replace it.

We reserve the right make the changes in our privacy practices provided that such changes are permitted by applicable law and the new terms are effective for all protected health information that we maintain, including medical information we created or received before we made the changes. We will provide you with a revised notice in person during your next office visit. You may also request a copy of our notice (or any subsequent revised 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 Protected Health Information

Uses and Disclosures Without Your Written Authorization

We may use and disclose your PHI about you for treatment, payment, and health care operations.
Following are examples of the types of uses and disclosers of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party or to other physicians who may be treating you. For example, we would disclose your PHI to other physicians in order to diagnose or treat you. In addition, we may disclose your PHI from time to time to another physician or health care provider (e.g. 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.

Payment: Your PHI may be used as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you,
such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use disclose, as needed, your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you.

We will share your PHI with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice.

Whenever an arrangement between our office and a business associates involves the use or disclose of your PHI, we will have a written contact that contains terms that will protect the privacy of your PHI. We may use or disclose your PHI, as

necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
We may use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. In order to receive this information, we are required to obtain an authorization from you. Should you not wish to receive these marketing materials, you may opt out on the authorization.

Uses and Disclosures Based On Your Written Authorization:

a. **Research; Death; Organ Donation:** We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

b. **Public Health and Safety:** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.
c. **Health Oversight:** We may disclose protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or of others. We may disclose your 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.

d. **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

e. **Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

f. **Criminal Activity:** Consistent with applicable state and federal laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend and individual.

g. **Required by Law:** We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws. We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

h. **Fugitive, material witness, crime victim, or missing person:** We may disclose protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

i. **Specialized Government activities:** We may disclose your protected health information for military, national security, and prisoner purposes.

Your Protected Health Information Rights:

a. **Access:** You have the right to look at or get copies of your protected health information, with limited exceptions. You may request electronic copies of your protected health information contained in electronic health records or you may request in writing or electronically that another person receive an electronic copy of your records. If you request a copy of your electronic records, it will be provided in the format requested or in a mutually agreed-upon format. We may charge you for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $____ each page, or $____per hour for staff time locate and copy your protected health information that is not electronic, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure. We may disclose your protected health information following your death to a family member or close personal friend who was involved in your care or payment prior to your death, however, we will not disclose any information if we are aware that you would not have wanted disclosure of your protected health information.

b. **Accounting of Disclosures:** You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for the purpose other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

c. **Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your protected 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). Any agreement we may make a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

d. **Confidential Communication:** You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continue to permit us to bill and collect payment from you.

e. **Amendment:** You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reason. If we deny your request, we will provide you a written explanation. You may respond with a information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

f. **Right to Restrict Disclosure to a Health Plan:** You have the right to restrict that we not share your protected health information with a health plan for payment or operations purposes if the protected health information relates to services for which you paid in full. For example, rather than allow us to file a claim with your health insurance carrier for treatment of a specific medical condition, you chose to pay for the treatment in full, then you can restrict us from sharing your protected health information related to that specific service with your health insurance plan.

g. **Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain the notice in written form.

Questions & Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. 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: Joshua Kuykendal

Address: 913 Spring Cypress Rd, Spring, TX 77373 Telephone: 281-353-9797

Fax: 281-288-9797