Patient Registration

First Name: ____Last Name: ____ Middle Initial: ____

Preferred Name: _____________________

Patient is: ___ Policy Holder ___ Responsible Party

Address: ____ City _____________________ State/Zip ________________

Home Phone: ____________________ Cell Phone: ______________________ Work Phone: ________________________

Sex: ___ Male ___ Female Marital Status: __ Married __ Single __ Divorced __ Widowed

Birth Date: __________________ Age: ____ Social Security: _________________________ Drivers License: _________________

Email: ____

Employment Status: ___ Full Time ___ Part Time ___ Retired

Student Status: ___ Full Time ___ Part Time

Emergency Contact Name and Phone: ____ Relationship: ____________

Responsible Party (if someone other than patient)

First Name: ____ Last Name: ____ Middle Initial: ____

Address: ____ City _________________________ State/Zip ________________

Home Phone: __________________ Cell Phone: __________________Work Phone: ____________________

Birth date: _________________ Soc Sec: __________________ Drivers License: _______________________

Sex: ___ Male ___ Female Marital Status: __ Married __ Single __ Divorced __ Widowed

Email: ____

Primary Insurance Information

Name of Insured: ____ Relationship to Insured: _____________

Insured Soc Sec: ________________________ Insured Birth Date: _________________

Employer: _______________________________________ Insurance Company Name ________________________________

Insurance Company: ______________________________ Provider Insurance Phone Number __________________________

Secondary Insurance Information

Name of Insured: ___________________________ Relationship to Insured: ______________

Insured Soc Sec: ______________________ Insured Birth Date: __________________

Employer: _______________________________ Insurance Company Name _________________________________

Insurance Company Address: _______________________ Provider Insurance Phone Number ___________________________

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 you may be taking, could have an important interrelationship 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 taken or have you taken Phen-fen or Redux? __yes __no If yes please explain: ____
Have you ever taken Fosamax, Boniva, Actonel or any
Other medications containing bisphosphonates: __yes __no If yes please explain: ____
Are you on a special diet? __yes __no
Do you use tobacco? __yes __no Do you use controlled substances __yes __no

Women: Are you
Pregnant/trying to get pregnant __yes __no Taking oral contraceptives? __yes __no Nursing? __yes __ no

Are you allergic to any of the following?
__Aspirin __Penicillin __ Codeine __Acrylic __Metal __Latex __Local Anesthetics

__ Other: please explain ____

Do you have, or have you ever had, any of the following? Please check if applicable.

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

Have you ever had any serious illness not listed above? ___yes ___ no If yes, please explain: ______________________________________

Comments: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the 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 __________________________________

HIPAA PRIVACY FORM 1

Notice Of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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Dr. Holly Doffing

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 (MM/DD/YR), 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 a 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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 a reasonable fee for copying which shall be no more than $25.00 for the 1st 20 pages and $0.15 for each page thereafter, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your 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.)

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.

Restriction: 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.

Dr. Holly Doffing

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: Pam Smith

Telephone: 281-491-9177 Fax: 281-491-5576

E-mail: hollydoffingdds@windstream.net

Address: 4724 Sweetwater Blvd., Suite 106 Sugarland, TX 77479

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Dr. Holly Doffing

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

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Dr. Holly Doffing

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Dr. Holly Doffing

The undersigned patient hereby authorizes 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 patient's dental needs. I also authorize the Doctor to perform any and all treatment, medication, and therapy that may be indicated. I also understand the use of local anesthetic agents embodies a certain risk. The Doctor will completely explain all procedures before they are performed. The patient agrees to pay an infection control fee of $10.00, on a per visit basis when anesthesia is administered, and knows that this charge is not covered by insurance. I understand that the dental office will file my dental insurance for me as a courtesy, and any fees incurred are ultimately my responsibility, and that the insurance contract is between me, the patient, and my insurance company, and not the Doctor and the insurance company. The patient will be responsible for any co-payments at the time of service. The patient or responsible party accepts full responsibility for any amounts not paid or covered by the insurance company. Co-payments are due and payable at the time services are rendered. Any payments received by the Doctor from a patient's insurance company will be credited to the patient's account, or refunded to the patient if fees were paid in full at the time of service.

The patient or responsible party acknowledges and agrees to pay a charge for any missed or broken appointments without proper 24hour notification.

PATIENT Signature (Parent of Child) ______________________________Date________