WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (____) _____ Cell Phone (____) _____

Name _____ SS/HIC/Patient ID #_____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____Zip _____

Sex: □ M □ F Age _____ Birthdate _____ □ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for ____years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ID#/SS# _____

Address (*if different from patient's*) _____Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company
_____

Contract # _____ Group # _____Subscriber # _____

Additional Insurance

Is patient covered by additional insurance? □ Yes □ No

Subscriber Name _____ Relation to Patient _____Birthdate _____

Address (*if different from patient's*) _____Phone (____) _____

City _____State _____ Zip _____

Subscriber Employed by _____Business Phone (____) _____

Insurance Company _____SS # _____

Contract # _____ Group # _____Subscriber # _____

Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaws
□ Food collection between teeth
□ Grinding teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores/growths in mouth

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you had any serious illnesses or operations? □ Yes □ No If yes, describe _____

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (✓) if you have had problems with any of the following:

□ Anemia
□ Arthritis, Rheumatism
□ Artificial Heart Valves
□ Artificial Joints
□ Asthma
□ Back Problems
□ Blood Disease
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Cortisone Treatments
□ Cough, Persistent
□ Cough up blood
□ Diabetes
□ Epilepsy
□ Fainting
□ Glaucoma
□ Headaches
□ Heart murmur
□ Heart Problems
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ HIV/AIDS
□ Jaw Pain
□ Kidney Disease
□ Liver Disease
□ Mitral Valve Prolapse
□ Pacemaker
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Skin Rash
□ Stroke
□ Swelling of Feet/Ankle
□ Thyroid Problems
□ Tobacco Habits
□ Tonsillitis
□ Tuberculosis
□ Ulcer
□ Venereal Disease

Medications *(please list medications you are currently taking)*

_____

_____

Allergies *(please list if any)*

_____

_____

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved!

601 W. F.M. 544 Suite 108
Murphy, T X 75094-4227
Phone (972) 516-2928 /Fax (972) 423-4511
Email: MFD@Murphyfamilydentistry.com

Dental Treatment Consent Form

1. **Health Information**
   I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medications, allergies, or illness are risk factors.

2. **Drugs, latex and medicines**
   I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat and depending on my health may be dangerous to me.

3. **Needle Stick**
   If someone is inadvertently stuck with needles used on me, I consent to have blood drawn for analysis.

4. **Fillings, Crowns and Un-anticipated Root Canals**
   Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling and crown is done.

5. **Root Canal Failure**
   Root canals can fail and may require additional treatment or I may end up having the tooth extracted.

6. **Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings**
   Porcelain Crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

7. **Gum Treatment and Requesting "Just a Cleaning"**
   If I don't floss or if I smoke, I can expect to have a deteriorating gum condition. I agree that if I need gum treatment, I will NOT insist that I simply get a cleaning (prophylaxis)

8. **Extractions and Surgery**
   I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis.

9. **Fee for Additional or Specialty Care**
   I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for the additional or specialty care.

10. **Limitations of Insurance Coverage**
    There are charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover.

11. **24 hour Notice of Cancellation**
    I agree to give a 24-hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the day (or weekend) before is NOT sufficient notice.

12. **Requesting Record Transfer**
    Professional courtesies are between dentists. I agree not to request records until I have a new dentist.

13. **Hygiene Appointments**
    If I am more than 15 minutes late for my cleaning appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

Patient Name (Printed): _____

_____

Signature of patient or legal minors Date Witness

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FINANCIAL POLICY

Thank you for choosing Murphy Family Dentistry as your dental care provider. Our greatest concern is your complete oral health. Anything we do or say will be centered on that philosophy. It is suggested that each patient is seen every six months (or as needed) to ensure this preventative philosophy is met. We are committed to your treatment being successful, and to the return and maintenance of your good oral health. Please understand that payment of your bill is considered part of that treatment. The following is a statement of our **Financial Policy**, which we ask you read, and sign prior to any treatment.

_____ **PAYMENT FOR SERVICES RENDERED:** Patients are responsible for payment of all services rendered on their behalf or their dependents. Payment is due at the time of service unless other financial arrangements have been made in writing in advance.

_____ **INSURANCE ASSIGNMENT:** We may accept assignment of insurance benefits; however, most insurance plans **do not** cover 100% of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, please keep in mind that some, and perhaps all, of the services are not considered reasonable and necessary under the provisions of your insurance plan. **If this office accepts your insurance companies' assignment, it does not absolve the patient's responsibility for the charges in full for the treatment rendered.** We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that company's assignment. If your insurance company has not paid your balance in full within 90days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. This office cannot render services on the assumption that our fees will be paid be your insurance company.

_____ **INSURANCE FACTS:** Some insurance companies set their fee schedule unrealistically low to limit the amount they must pay in benefits. This does not mean that our fees are too high. We set our fees according to a national dental fee survey. Most insurance companies have a yearly deductible. You will need to know what your deductible is and pay that amount before your insurance company will begin to pay benefits.

_____ **DEFAULT ON PAYMENT:** In the event default on payment, the patient (guardian) promises to pay any and all collection costs and attorney fees as may be required to effect collection of this account.

Patient(s) Name *(please print)*: _____

_____

Signature of Patient or Legal Guardian Date Witness

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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 ___/___/___, 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 significant change in our privacy practices, we will change this Notice and make a 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 o 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 on 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 reasonable 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 and safety of others.

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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 duplicate x-ray copies, we will charge you $25 dollars for copies and staff time to locate and copy your health information, 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, 2004. 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 (email), you are entitled to receive this Notice in written form.

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 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 may also submit a written complaint to the US Department of Health and Human Services. We will provide you r with the address to file your complaint with the US 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 US Department of Health and Human Services.

Contact Officer: Dawn Herzog

Telephone: (972) 516-2928 Fax: (972) 423-4511

Email: mfd@murphyfamilydentistry.com

Address: 601 W. FM 544 Suite 108, Murphy, TX 75094-4227

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE 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

I authorize the following individual(s) permission to discuss my treatment/financials:

_____ _____
Name Relationship

_____ _____
Name Relationship

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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Communication Release Form

I give my consent for Murphy Family Dentistry to communicate with me via e-mail, phone, text, mail or other media about products or services that pertain to my conditions or that can contribute to matters related to my health and/or my medical treatment. I understand my Protected Health Information may be referenced to determine that I may be a likely candidate for products or services that my dental health practitioner may share with me.

Please check all methods in which we can communicate with you:

- ☐ Email: _____
- ☐ Phone:
  Home: _____
  Mobile: _____
- ☐ Text:_____
  (Carrier charges/fees may apply. We are not responsible for any carrier fees to your account.)

Murphy Family Dentistry may communicate with me about my oral health, treatment, appointments, and pot-operative follow ups by mail, email, text, or my phone to the contact information on file. It is my responsibility to ensure all my contact information is up-to-date.

I understand that communication between Murphy Family Dentistry and I may not be encrypted and my information could be intercepted by unauthorized persons.

Murphy Family Dentistry will not be responsible for any unauthorized interceptions, however we will make reasonable measures to ensure proper delivery or notification of our patient's information. Examples include, but are not limited to, post-operative phone calls and appointment reminders.

This consent remains in effect until expressly revoked (in writing).

Printed Name: _____

Signature: _____Date_____