SUSAN HENSON
DMD, PA

Please fill out this form as completely as possible. The better we communicate, the better we can care for you!

Name_____ I prefer to be called _____

DOB _____/_____/_____ SS# _____-_____-_____ Email Address _____

Address_____ City_____ St. _____ Zip Code_____

Hm (_____)_____-_____ Cell (_____)_____-_____ Employer_____Ph (_____)_____-_____

Emergency Contact Name _____ Ph# (_____)_____-_____ Relation_____

Physician Name _____ Ph# (_____)_____-_____ Last Physical Exam _____/_____/_____

How did you hear about us? _____ Last Dental Exam _____/_____/_____

DO YOU, OR HAVE YOU EVER, HAD ANY OF THE FOLLOWING?

Breathing/Respiratory problems			Thyroid Problems	**Y**	**N**
Asthma	**Y**	**N**	Diabetes	**Y**	**N**
History of tuberculosis (TB)	**Y**	**N**	Artificial Bones, Joints, Valves (circle one)	**Y**	**N**
High or Low blood pressure (circle one)	**Y**	**N**	Depression or Psychiatric Problems (circle one)	**Y**	**N**
Stroke	**Y**	**N**	Alcohol or Drug Abuse (circle one)	**Y**	**N**
Heart Attack or Angina (circle one)	**Y**	**N**	Fibromyalgia	**Y**	**N**
Heart Surgery or Pacemaker (circle one)	**Y**	**N**	Sleep Apnea	**Y**	**N**
Congenital Heart Defect	**Y**	**N**	Cancer (If yes, what type?)_____	**Y**	**N**
Artificial Heart Valves	**Y**	**N**	Chemotherapy	**Y**	**N**
Coronary Artery Disease	**Y**	**N**	Radiation Therapy	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	ALLERGIES TO ANY OF THE FOLLOWING:		
Rheumatic Fever	**Y**	**N**	Latex	**Y**	**N**
Ulcer, GERD, Colitis (circle one)	**Y**	**N**	Penicillin	**Y**	**N**
Epilepsy or Seizures (circle one)	**Y**	**N**	Codeine, Aspirin, or other pain meds (circle one)	**Y**	**N**
Liver Disease	**Y**	**N**	Dental Anesthetics	**Y**	**N**
Kidney Disease	**Y**	**N**	Other	**Y**	**N**
Hepatitis A, B, or C (circle one)	**Y**	**N**	If yes, please explain _____		
HIV positive	**Y**	**N**	FEMALE PATIENTS ONLY:		
Osteoporosis, If yes, have you taken	**Y**	**N**	Pregnant or Nursing	**Y**	**N**
Bisphosphonates? _____			Using a prescribed method of birth control	**Y**	**N**

Have you ever had any serious medical conditions not listed on this form? _____

Have you been hospitalized in the past 5 years and for what? _____

Do you smoke or use tobacco of any form? **Y** **N** Are you interested in quitting? **Y** **N**

Are you currently or have you ever taken blood thinners? **Y** **N** If yes, please list _____

Why have you come to the dentist today? _____ Have you ever required antibiotics before dental treatment? **Y** **N**

Please list each ***prescription*** drug you are taking:

_____

_____

_____

The information I have given today is correct to the best of my knowledge. I understand this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____/_____/_____

Signature **Date**

Annual Review of Medical History

_____/_____/_____ _____/_____/_____

Signature Date Signature Date

SUSAN HENSON
DMD, PA

Financial Policy and Assignment of Benefits

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy and an Assignment of Benefits. Thank you for your time in reading and understanding this important document.

Regarding Payment

We Accept the following forms of payment: Cash, Check, Visa and MasterCard. Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor or the billing receptionist. Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract; however in most cases as a courtesy to our patients we will file your insurance claim. In the event we do accept assignment of benefits from your insurance company and your insurance company has not paid your account in full within 60 days, the balance then becomes your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services. Your insurance company may only pay for selected treatment or they may not cover any of the treatment provided to you. You are responsible for payment in the event your insurance company does not cover the complete cost of treatment provided to you.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. We will do our best to verify your insurance benefits and provide you with an accurate estimate of your cost of treatment. However, please understand that this is simply an estimate and may change once final payment is received from your insurance company. As a courtesy we will file your insurance claim(s) with one insurance company. All insurance copays and deductibles must be paid at the time of service.

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to Susan Henson, DMD, PA for dental services rendered to myself and /or my dependents. I understand that I am responsible for any amount not covered by my insurance.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly at 512-756-4256 for assistance in the management of your account. Please let us know if you have any questions or concerns.

I have read the Financial Policy and Assignment of Benefits. I understand and agree to the Financial Policy and Assignment of Benefits.

Printed name of Patient or Responsible Party:_____

Signature of Patient or Responsible Party:_____

Date:_____/_____/_____

SUSAN HENSON
DMD, PA

Patient Consent for Use and Disclosure

of Protected Health Information

I hereby give my consent for Susan Henson, DMD, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

The Notice of Privacy Practices describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Susan Henson, DMD, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Susan Henson, DMD, PA, 811 N. Water St, Burnet, TX 78611.

With this consent, Susan Henson, DMD, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Susan Henson, DMD, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Susan Henson, DMD, PA may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Susan Henson, DMD, PA restrict how it uses or disclosed my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Susan Henson, DMD, PA to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Susan Henson, DMD may decline to provide treatment to me.

Print Name of Patient or Legal Guardian, if applicable_____

Signature of Patient or Legal Guardian:_____

Patient's Name:_____

Date:_____/_____/_____

Notice of Privacy Practices is on the next page

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 April 14, 2003, 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

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, 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 website or by electronic mail (e-mail), 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 at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 on this website. 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: Cody Henson
Phone: 512-756-4256
Fax:512-756-7955
Address: 811 N. Water St.
Burnet, TX 78611