# PATIENT INFORMATION RECORD

## *PERSONAL INFORMATION*

Name _____

Street Address _____

City, State, Zip _____

Home Phone _____ Date of Birth _____

Work Phone _____ Social Security # _____

Cell Phone _____ Age _____

E-Mail Address _____

Person to contact in case of emergency _____ Phone _____

Whom may we thank for referring you? _____

## *EMPLOYER INFORMATION*

Name _____

Address _____

Occupation _____

## *RESPONSIBLE PARTY or INSURED (IF OTHER THAN PATIENT)*

Name _____

Address _____

Home Phone _____ Date of Birth _____

Work Phone _____ Social Security # _____

## *DENTAL HISTORY*

Reason for today's visit _____

Date of last dental care _____ Date of last dental x-rays _____

Former Dentist _____

## *MEDICAL HISTORY*

**Please check ( X ) if you have had any of the following, and describe:**

- ❑ Joint replacements, metal rods/pins, etc. _____
- ❑ Have you ever been hospitalized or had a major operation? _____
- ❑ Have you ever had a serious head or neck injury? _____
- ❑ Do you use tobacco? _____

**Please check ( X ) if you have, or have had any of the following:**

- ❑ Asthma
- ❑ 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 Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Heart Attack/Failure
- ❑ Heart Murmur
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Head/Neck injury
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heart Beat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Pain In Jaw Joints
- ❑ Parathyroid Disease
- ❑ Periodontal / Gum Surgery
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice

**Are you allergic to:**

- ❑ Aspirin
- ❑ Penicillin
- ❑ Codeine
- ❑ Acrylic
- ❑ Metals (Nickel, Mercury, etc.)
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Other _____

**Women Only:**

- ❑ Are you pregnant (or think that you may be)?
- ❑ Are you nursing?
- ❑ Taking Oral Contraceptives?

→ **Please list any other allergies or serious illnesses not addressed above:**

_____

→ **Please list any medications or drugs that you are currently taking, if any:**

_____

_____

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 the 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**

Scott R. Alexander DDS PLLC
3601 Regent Blvd. #155
Irving, TX 75063

## WELCOME TO OUR PRACTICE

Thank you for choosing us as your dental care provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment. We accept **Cash, Check, Debit Cards, Visa, Mastercard, Discover,** and **American Express**. We do not have any type of payment plans and **PAYMENT FOR ANY PROCEDURE NOT COVERED BY INSURANCE or PATIENT COPAYS WILL BE COLLECTED AT THE TIME OF SERVICE**. However, our office does participate with a few financing companies and any information is available in the front office. Should your account go into collection services, you will be responsible for the collections fees and account recovery. Please read carefully and sign at the bottom of the page indicating your understanding of our policies and procedures.

## GENERAL OFFICE POLICIES

We believe your time is as valuable as ours. We do try our best to accommodate our patient's needs and in the case of emergencies, we will try our best to see you at the earliest appointment available. We do also try our best to avoid any delays to you. Please assist us in our efforts to stay on time in the following ways.

- Please arrive on time for your scheduled appointment. **If you are more than 15 minutes late it may be necessary to reschedule your appointment for a later time.**
- Our receptionists and front office personnel are required to keep patient demographic information as up to date as possible. Please understand that we may ask you for any change of address, phone number, or changes in medical history on subsequent visits. This information helps us to better serve you.
- Please realize that it is each individual's responsibility to keep track of appointments made. Please remember that we do remind our patients of scheduled appointments the day before as a courtesy only. However, on occasion you may not receive a reminder call. Please realize it is each individual's responsibility to keep track of appointments made.
- If you need to cancel an appointment, please give us 24 hours notice so that we may schedule another patient in the time slot reserved for you. ***If you do not cancel your appointment 24 hours in advance, a $50.00 fee may be charged (except in cases of emergencies or illness) and is payable prior to future visits. For Saturday appointments, broken appointment fees will be fully enforced.***
- Any returned checks are subject to a **$25.00** service fee and will also be turned over to the constable's office if not taken care of within 7 business days.
- **Treatment will be denied for any unaccompanied minors. Parents or guardians must accompany minors to all dental visits.**

## INSURANCE

Our practice is committed to providing the best treatment for our patients. We must emphasize that as Dental Care provider, our relationship is with you, our patient, not with your insurance company. **WE DO NOT WORK FOR YOUR INSURANCE COMPANY.** We will make every effort to collect benefits from the insurance company; however, if a claim is not paid within 60 days then the patient will be responsible for any claims over 60 days. **While the filing of insurance claims is a "Courtesy" that we extend to our patients, all charges are your responsibility from the date of the services rendered.** Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. If an alternate benefit provision exists on your plan, we recommend you familiarize yourself with your plan, as our office will automatically provide cosmetically inclined restorations, unless otherwise indicated by you, the patient. We cannot guarantee payment of all claims; we can only **ESTIMATE what your copay will be.** Insurance policies may change and/or insurance company representatives do not always give us correct or consistent information. **We ask that you become familiar with any plan exclusions or provisions under your plan. Many insurance companies are now *DOWN GRADING* posterior restorations or paying according to the *ALTERNATE BENEFIT* or the least expensive procedure. In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered.**

**We thank you for understanding our financial policies. This has become necessary in order to continue to accept insurance plans without having patients pay the balance up front and then wait themselves for reimbursement from their insurance company. Our goal is to make your visit with us pleasant and professional. If you have any questions, please feel free to ask our staff for assistance. Thank you again for choosing us for your dental care.**

**Patient Name** **Signature** **Date**

# SCOTT R. ALEXANDER, DDS, PLLC

**3601 Regent Blvd.**
**Suite 155**
**Irving, Texas 75063**
**972.915.4040**


## ATTENTION: REDUX OR FEN-PHEN USERS

If you have ever used Redux or Fen-Phen alone or with other weight loss medications please notify us. The potential heart valve damage caused by Fen-Phen or Redux makes you susceptible for Bacterial Endocarditis when you undergo dental procedures. It has been strongly recommended by the Food and Drug Administration along with the Centers for Disease Control and Prevention and the National Institutes of Health that you have an evaluation and possible echocardiogram by your physician prior to undergoing any dental procedures. Failure to diagnose heart valve damage from Redux or Fen-Phen could result in bacterial colonization of the affected valve, necessitating valve replacement.

Thank you for notifying us of this update of your medical history.

**Please check one of the following:**

❑ **I have never taken any form of Redux or Fen-Phen**

❑ **I have taken Redux or Fen-Phen.**
**Dates Taken** _____

_____

**Patient or Guardian Signature** **Date**

**Your signature certifies understanding of the above statement.**

# NOTICE OF PRIVACY PRACTICES
## SCOTT R. ALEXANDER DDS PLLC

### 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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect at your first date of service 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

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**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

**Treatment.**We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

**Payment.**We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

**Healthcare Operations.**We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

**Individuals Involved in Your Care or Payment for Your Care.** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

**Disaster Relief.**We may use or disclose your health information to assist in disaster relief efforts.

**Required by Law.**We may use or disclose your health information when we are required to do so by law.

**Public Health Activities.**We may disclose your health information for public health activities, including disclosures to:
- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

**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 the protected health information of an inmate or patient.

**Secretary of HHS.**We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

**Worker's Compensation.** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

**Law Enforcement.**We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

**Health Oversight Activities.**We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Judicial and Administrative Proceedings.**If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

**Research.**We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

**Coroners, Medical Examiners, and Funeral Directors.**We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

**Marketing.** We will not use or disclose your health information for marketing communications of any kind.

**Appointment Reminders.** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**Other Uses and Disclosures of PHI**

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**Your Health Information Rights**

**Access.** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

**Disclosure Accounting.**With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

**Right to Request a Restriction.**You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

**Alternative Communication.** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

**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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

**Right to Notification of a Breach**. You will receive notifications of breaches of your unsecured protected health information as required by law.

**Electronic Notice.**You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

**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 if 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.

Our Privacy Official: Renae Baker
Telephone: 972-915-4040
Fax: 972-915-4343
Address: 3601 Regent Blvd., Suite 155, Irving, TX 75063
E-mail: drscottalexander@yahoo.com

**Authorization to Share Clinical Information:** If you would like to give us your permission to share your clinical information or to answer questions from another person, (such as your spouse or parent) please indicate that below.

Name: _____ Relationship _____

Name: _____ Relationship _____

By way of signature, I provide this practice with my authorization and consent to use and disclose my protected health information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date