Welcome to Pine Cove Dental

Our mission is to provide you and your family the best and most compassionate dental care possible. We believe in building great relationships and treating you as a person and not just another set of teeth to clean or fix. Please fill out this form completely so that we can get to know you better. Thank you for trusting us with your dental care & welcome to our office! - Dr. Levy Do

Patient Information

Patient Name: _____ Date:_____
Last First MI Preferred Name

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security #: _____ DOB:_____Email:_____

Phone (Home): _____ (Work): _____(Cell):_____

Your Address:_____
Street City State Zip

Employer Name: _____ Occupation:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ Allergies to:_____
- ☐ Aspirin
- ☐ Codeine
- ☐ Sulfa Drugs
- ☐ Erythromycin
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline

Other_____
_____

☐ Anemia
☐ Arthritis
☐ Artificial Joints/Valves
☐ Asthma
☐ Blood Transfusion
☐ Cancer/Chemotherapy
☐ Diabetes
☐ Dental Anxiety
☐ Epilepsy / Seizures
☐ Emphysema
☐ Excessive Bleeding
☐ Fever Blisters/ Herpes
☐ Glaucoma
☐ Heart Attack / Stroke
☐ Heart Murmur
☐ Heart Surgery/Pacemaker
☐ Hepatitis
☐ High/Low Blood Pressure
☐ HIV / AIDS
☐ Hospitalization
☐ Jaundice
☐ Kidney Problems
☐ Liver Problems
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Psychiatric Care
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Severe Headaches
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Sleep Apnea
☐ Snoring
☐ Current Smoker/Dipper
☐ Tuberculosis (TB)
☐ Tumors
☐ Ulcers / Colitis
☐ Venereal Disease
☐ OTHER:_____
☐ OTHER:_____

WOMEN: Are you pregnant?
☐No ☐Yes #of Weeks____

- Do you have any health problems that need clarification? ☐ Yes ☐ No If yes, please explain: _____
_____
- Do you require antibiotic premedication ☐ Yes ☐ No
- Name of Physician: _____ Phone:_____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain:
_____
- Please list **any** prescription, over-the-counter drugs, vitamins, or herbal supplements you are taking: _____
_____
- How did you hear about our practice? ☐ Another patient, friend, or relative ☐ Dental Office ☐ Internet ☐ School ☐ Yellow Pages ☐ Newspaper / Magazine ☐ Work ☐ Other_____

Whom may we thank for referring you to our practice? _____
(Name of person or office referring you to our practice)

- What are your personal interests or hobbies? _____
- Is there anything or anyone you would like to add to our prayer list? _____

_____ _____
Signature of patient, parent or guardian Date Dentist Signature – Pine Cove Dental

Dental Information

Why have you come to the dentist today? _____

☐ Yes ☐ No Has your doctor ever told you that you require antibiotics before dental treatment?
☐ Yes ☐ No Have your ever had a serious / difficult problem associated with any previous dental work?
☐ Yes ☐ No Do you have, or have you ever experienced pain /discomfort in your jaw joint (TMJ / TMD)?
☐ Yes ☐ No Are you currently having dental pain?
☐ Yes ☐ No Have you ever had a toothache?
☐ Yes ☐ No Have you ever fractured or cracked a tooth?
☐ Yes ☐ No Are you concerned about your silver / mercury fillings?
☐ Yes ☐ No Have you noticed spots, stains, or chips on your teeth that concern you?
_____ On a scale of 1 -10 (with a 10 being BEST), how would you rate your smile?
☐ Yes ☐ No Have you ever considered whitening your teeth?
☐ Yes ☐ No Have you ever considered straightening your teeth?
☐ Yes ☐ No Do you have any place where food gets trapped between your teeth or areas that are difficult to floss?
☐ Yes ☐ No Have you ever been told that you have, or have you ever been treated for, gum disease (periodontitis)?
☐ Yes ☐ No Would you like to keep your teeth for the rest of your life?

How many times a day do you brush your teeth? _____ What do you use to clean between your teeth? _____

How would you rate your dental health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last cleaning/exam:_____ Previous Dentist: _____ City: _____

What did you like most about any dentist you have seen?_____Least ?_____

Why did you leave your previous dentist? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ DOB: _____ SSN: _____

Address: _____

Phone (Home): _____ (Cell): _____

Employer Name: _____ Work Phone:_____

Relationship to Patient: _____

Insurance Information

Name of Insured: _____DOB: _____ SSN: _____

Insured's Address:_____ Phone: _____

Insured's Employer Name: _____ Phone: _____

Insurance Company Name: _____ Phone: _____

Group #: _____ Insured's ID #: _____

Consent for Services

With my signature below, I authorize:

- The dental staff of Pine Cove Dental to perform any necessary dental services required during my diagnosis and treatment, with my informed consent.
- The release of any information necessary to process insurance claims.
- If I request payment arrangements for services rendered, the generation of a credit report/inquiry.

_____ _____ _____

Printed Name Signature of patient, parent or guardian Date

PINE COVE
FAMILY & IMPLANT DENTISTRY

We value you as a patient and appreciate you trusting us with your dental treatment. In order to provide you with the best care possible, we have established the following policies with your safety and interest in mind. Please review the following and sign this agreement confirming you have read and accepted these policies. If you have any questions, please allow one of team members to provide you with an answer before signing.

Hours of operation:

- Monday: 10:00am – 6:00pm
- Tuesday and Wednesday: 8:00 am - 4:00 pm
- Thursday: 7:00 am – 3:00 pm
- Friday: 10:00 am – 6:00 pm

Cancellation and Re-scheduling:

- We value and respect your time. Scheduled appointments are reserved especially for you and the proper amount of time is carefully considered and scheduled for each planned procedure.
- As such, **we require <u>at least 48 hours of notice</u> for ANY cancellation or changes to your scheduled appointment.** This will allow us adequate time to meet the scheduling needs and demands of our patients. Any re-scheduled appointment within 24 hours of appointment time is considered as a No-Show.
- **We reserve the right to charge a <u>$50 per hour No-Show Fee</u>. If more than 2 No-Shows in a 4 month period occur, we will no longer be able to reserve scheduled time for you.**
- We understand that emergency situations occur that prevent patients from giving advance notice of the need to cancel an appointment. We will consider such situations on a case-by-case basis.

Treatment of Children and Minors:

- <u>Our standard policy for patients under the age of 18 (minor) is that a parent or legal guardian must be present throughout the entire treatment</u>. For patients of record, we will allow you to leave temporarily, if necessary, for routine dental procedures such as cleaning and checkups. For other procedures, please inquire BEFORE the appointment if you cannot be physically present. This policy is to ensure the safety of your child/children.

Consent for Treatment

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostics aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.
- Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Appointment Reservation Deposits & Payment Policy:

In order to reserve your treatment time with our Doctor/Hygienist for major treatments, we require a 50% payment deposit which fully applies towards your scheduled treatment. The remainder of your payment is required at the time service is rendered, unless prior financial arrangements have been made.

For your convenience, we accept the following methods of payment besides cash:

Care Credit Notice: Effective 09/01/2019 – All Care Credit transactions less than $3,000 is subject to a convenience fee of 5% of the transaction amount.

Dental Insurance

- Individualized quality dental care and building a lifelong relationship with you is important to us. Our professional services are rendered to you as the patient and not to your insurance company. Diagnoses of your dental needs are not based upon what your insurance company will allow but rather individual needs. Our office will prepare the patient's insurance forms and submit them electronically as a courtesy. Any remaining balance that is not covered by your insurance plan will be your responsibility. We will do our utmost to help you derive the maximum benefits to which you are entitled. Any insurance dollar amounts or percentages discussed with you by representatives of Pine Cove Dental are ESTIMATES of your benefits only. In signing this agreement, you understand that your insurance company determines what they will pay upon receipt of your claim; there is no guarantee expressed or implied by Pine Cove Dental that any specific insurance payment amount will be paid. Therefore, you are directly responsible for 100% for all services rendered in the absence of payment from your insurance company.
- We allow up to 30 days for your insurance company to make payment. After this time, the claim will be closed and you will be responsible to pay for your balance in full. All inquiries and necessary follow up for reimbursement from your insurance become your responsibility.

Treatment Options: I acknowledge that it is my responsibility to complete treatment and follow recommended maintenance schedules. If I do not proceed with my treatment plan in a timely manner, maintenance plans are not followed, and/or appointments are missed, adverse results could affect my dental health.

Treatment Fees: Fees are valid for 30 days from treatment plan presentation and are subject to revision. Treatment could be altered if your dental needs change. You will be notified of any change(s) in your treatment plan.

By signing this form, I acknowledge, understand, and agree to the above policies and obligations. I have had full opportunity to discuss and ask any questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Patient Name (printed)	Patient/Parent/Guardian Signature	Date
Witness Name (printed)	Witness Signature	Date

PINE COVE
FAMILY & IMPLANT DENTISTRY

PATIENT PHOTOGRAPHY RELEASE FORM (Optional)

Patient Name: _____
Last First MI Maiden or Other Name

Date of birth: _____/_____/_____ Phone Number: _____

From time to time, we may ask your permission to take your picture if you're selected as our Patient of the Day, or in special cases permission to use your dental photos for Dr. Do's Dental Seminars presentations and for teaching purposes.

We will always ask you before posting anything to social media. No personally identifiable information will be shown if your case is used for academic purposes.

Check below to grant Pine Cove Dental permission to take and use photographs and digital images of yourself for the following purposes:

- ❑ **Teaching (i.e. Dr. Do's Seminars and Case Presentations)**
- ❑ **Social Media Posting (i.e. Facebook, Website, Brochures, etc)**
- ❑ **Other:** _____

I understand that once my photograph(s) or digital image(s) have been released, Pine Cove Dental may no longer have control over them, and federal or state privacy laws may no longer protect the information that was released.

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already used my photograph(s) or digital image(s) prior to me canceling this authorization, which would not prohibit any release done prior to the date of cancelation.

To cancel this agreement, I must write a letter to the doctor or practice advising of my wish to cancel my authorization to release photograph(s) or digital image(s) taken of me by this practice. I (or my authorized representative) must sign and date the letter.

_____ _____
Patient Signature/Legal representative Date

_____
Relationship of legal representative

Pine Cove Dental

Dr. Levy Do, D.D.S.

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.

Print name

Signature

Date

THIS SECTION 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
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

PINE COVE
FAMILY & IMPLANT DENTISTRY

NOTICE OF PRIVACY PRACTICES

Effective Date: 10/17/2017

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.

CONTACT INFORMATION

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice, please contact our Privacy Officer.

Privacy Officer: Levy T. Do, DDS Telephone: (817) 453-8520 Fax: (817) 453-8522

Email: info@pinecovedental.com Address: 1560 E. Debbie Lane, Ste. 108, Mansfield, TX. 76063

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 on the date set forth at the top of this page, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices, and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make 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 the revised notice available upon request. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may disclose your Personal Health Information (PHI) in writing, by electronic media or your PHI could be transmitted or maintained in any other form or medium. Information we may disclose could be for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information, without your prior approval, to another dentist, a physician or other healthcare provider working in our facility or otherwise providing you treatment for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, your health information may be disclosed to an oral surgeon to determine whether surgical intervention is needed.

Payment: We provide dental services. Your medical information may be used to seek payment from your insurance plan. For example, your insurance plan may request and receive information on dates that you received services at our facility in order to allow your employer to verify and process your insurance claim.

Healthcare Operations: We may use and disclose your health information without your prior approval, for health care operations. Healthcare operations include:

- healthcare quality assessment and improvement activities;
- reviewing and evaluating dental care provider performance, qualifications and competence, or health care training programs, provider accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, adults, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, complaint resolutions and billing, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your health information to another dental or medical provider or to your health plan subject to federal privacy protection laws, as long as the provider or plan has or had a relationship with you and the medical information is for that provider's or plan's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You (or your legal personal representative) may give us written authorization to use your health information or to disclose it to anyone for any purpose. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your health information for any purpose other than those described in this notice. We will obtain your authorization prior to using you health information for marketing, fundraising purposes or for commercial use. Once authorized, you may opt out of any of these communications.

Family, Friends, and Others Involved in Your Care or Payment for Care: We may disclose your health information to a family member, friend or any other person you involve in your care or payment for your health care. We will disclose only the health information that is relevant to the person's involvement.

We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your care in appropriate situations, such as a medical emergency or during disaster relief efforts. We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Health-Related Products and Services: We may use your health information to communicate with you about health-related products, benefits, services, payments for those products and services, and treatment alternatives.

Reminders: We may use or disclose medical information to send you reminders about your dental care, such as appointment reminders.

Plan Sponsors: If your dental insurance coverage is through an employer's sponsored group dental plan, we may share summary health information with the plan sponsor.

Public Health and Benefit Activities: We may use or disclose your health information, without your permission, when required by law, and when authorized by law for the following kinds of public health and public benefit activities:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims and criminal activities;
- to coroners, medical examiners, funeral directors, and organ procurement organizations
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- As authorized by state worker's compensation laws.

Data Breach Notification Purposes: We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.

Additional Restrictions on Use and Disclosure: Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types on information:

1. HIV/AIDS;
2. Mental health;
3. Genetic Tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

YOUR RIGHTS

Access: You have the right to examine and receive a copy of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. You should submit your request in writing to our Privacy Officer. We may charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure of Accounting: You have the right to a list of instances in which we or our business associates disclose your health information for purposes other than treatment, payment, healthcare operations and certain other activities, as authorized by you. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

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).

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. You have the right to know that we regularly use email communication with physicians or other health care providers, as well as insurance companies regarding your dental treatment, health history or for insurance purposes.

Complaints

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 you may contact our Privacy Officer listed above. You also may submit a complaint to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

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.