PATIENT REGISTRATION

DATE__________________

PATIENT'S NAME____________________________________DATE OF BIRTH________________

NAME OF SPOUSE____________________________________ SINGLE_____MARRIED_______

STREET ADDRESS ____________________________________ DIVORCED_____ WIDOWED___

CITY_________________________________STATE____________ZIP_____________

E-MAIL ADDRESS__________________________PHONE ______________CELL_________________

PATIENT EMPLOYED BY___________________________________PHONE_____________________

BUSINESS ADDRESS____

PRESENT POSITION_______________________________________HOW LONG HELD___________

SPOUSE EMPLOYED BY___________________________________PHONE_____________________

BUSINESS ADDRESS____

PRESENT POSITION_______________________________________HOW LONG HELD___________

PURPOSE OF APPOINTMENT____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED__________________PHONE__________

PERSON RESPONSIBLE FOR THIS ACCOUNT____

SOCIAL SECURITY NUMBER____

SPOUSE'S SOCIAL SECURITY NUMBER______________________________DOB______________

IF YOU HAVE DENTAL INSURANCE, NAME OF INSURED________________________________

NAME OF INSURANCE COMPANY____________________________POLICY NO.______________

WHO MAY WE THANK FOR REFERRING YOU____

IS ANOTHER MEMBER OF YOUR FAMILY A PATIENT IN OUR PRACTICE___________________________________

WHEN WAS YOUR LAST DENTAL VISIT____

WHEN WAS THE LAST TIME YOU HAD COMPLETE DENTAL X-RAY TAKEN_________________DENTIST__________

I AUTHORIZE THE DOCTOR TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY THAT MAY BE INDICATED IN CONNECTION WITH THE DENTAL CARE OF THE PATIENT ABOVE AND FURTHER AUTHORIZE AND CONSENT THAT THE DOCTOR CHOOSES AND EMPOLYS SUCH ASSISTANT AS HE DEEMS FIT. I ALSO UNDERSTAND THAT PRIOR TO TREATMENT, FULL EXPLANATION OF THE PROCEDURE (S) INVOLVED WILL BE GIVEN BY THE DOCTOR AND\OR HIS STAFF. I AGREE TO PAY FOR ALL SERVICES RENDERED BY THIS OFFICE.

SIGNATURE OF RESPONIBLE PARTY RELATIONSHIP
DATE

MEDICAL HISTORY

Patient Name______________________
Date__________ Date of Birth________

Medical History:

Circle Below — 1. Do you have (or have you ever had) any of the following?

Yes No a. allergic reaction to drugs or latex (circle all that apply)
Latex Penicillin Aspirin Codeine Local anesthetics Metal Sulfas
Yes No b. heart attack or heart disease
Yes No c. stroke
Yes No d. high blood pressure
Yes No e. congestive heart failure
Yes No f. irregular heart beat
Yes No g. artificial heart valve
Yes No h. rheumatic fever, rheumatic heart disease
Yes No i. bacterial endocarditis (SBE)
Yes No j. congenital heart disease
Yes No k. heart murmur or mitral-valve prolapse
Yes No l. immunosuppressive condition (circle all that apply)
Steroid therapy (e-g prednisone) Radiation Therapy Chemotherapy SLE (Lupus)
Rheumatoid Arthritis HIV Organ Transplant Spleen removed Other

Yes No m. artificial joint(s) (circle all that apply) List dates placed ___/___/___
Hip Knee Ankle Shoulder Other mos day year

Yes No n. other artificial metal or titanium implants or devices
Yes No Are you taking Blood Thinners at this time?
Yes No o. bleeding problem, anemia, other blood disease
Yes No p. diabetes
Yes No q. thyroid disease
Yes No r. nervous system disease or seizures
Yes No s. stomach or intestinal disease
Yes No t. kidney disease
Yes No u. hepatitis (A, B, C or D)
Yes No v. other liver disease
Yes No w. arthritis (osteo or rheumatoid)
Yes No x. other muscle or joint disease
Yes No y. asthma
Yes No z. tuberculosis
Yes No aa. other lung disease
Yes No bb. mental health condition-specify:______________________
Yes No cc. physical or mental disabilities that may require special care
Yes No dd. Do you have or have you ever been treated for cancer?
Yes No ee. Are you or could you be pregnant? Yes No ff. Are you nursing?

Yes No 2. Do you have any disease, condition, or problem not listed here?
List condition here:___________________________________
____

Yes No 3. Have you ever been hospitalized or had surgery?
List Date and Reason here:______________________________

Yes No 4. Are you, or have you ever been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

Yes NO 5. Do you smoke or use tobacco products?

Yes No 6. Are you a past user of tobacco products?

Yes No 7. Have you undergone current or past osteoporosis therapy?
(examples are: Fosamax, Actonel, Boniva pill form)

Yes No 8. Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate therapy)? (Examples: intravenous Aredia, Zometa)

Physician List (please list your family physician and any medical specialists you see at least once a year):

Name Address City Phone# Name of Specialty

____
____
____

Please list all medications you are taking:______________________________________
____
____
____

Dental History

Chief Complaint: (Why are you seeking dental care?)____________________________

Yes No 1. Do you have regular dental check-ups?

2. When was your last dental exam?___________

Yes NO 3. Have you had any trouble associated with previous dental treatment?
If so please explain____

Yes No 4. Have you noticed any lumps or sores in your mouth?

Yes No 5. Do your gums bleed when you brush your teeth?

Yes No 6. Have you ever injured your face, jaws or teeth?

Yes No 7. Do you suffer from pain in the mouth, face eyes, neck or throat?

Yes No 8. Are you unhappy with the appearance of your teeth?

Yes No 9. Has fear ever prevented you from seeking dental treatment?

Yes No 10. Are you allergic to any metals or dental materials?

Yes No 11. Circle the types of dental treatment you have experienced?

Orthodontics (braces) Dentures Root Canal Implants Fillings
Oral surgery Periodontal (gum) treatment TMJ treatment
Crowns Bridges Veneers Bleaching Other____________

Dr. Joseph McCreary's Office Financial Policy

Non-insured patients are expected to pay in full with cash, check or credit card the day the services are rendered.

Insured patients will assign benefits from their dental insurance company directly to our office. You **must sign** the "Assignment & Release" portion of our Dental Registration Form. This allows your dental insurance company to make a payment directly to our office on your behalf. Most dental insurance plans to not cover 100% of the cost of your treatment. For this reason, you will be required to pay your deductible and an estimated portion of the charges the day the services are rendered. Please keep in mind that we are only **estimating** the amount that your insurance will pay once they receive the actual claim. You are ultimately financially responsible for your account balance, including any shortfall from your insurance company. As a courtesy to you, we will submit your claim to your dental insurance company for you. After 45 days, the balance will be due in full from you.

Missed appointments: A broken appointment is a loss to everyone. Please inform us one day in advance if you are unable to keep your appointment. There will be a **$35.00** Fee for missed appointments.

Feel free to ask any questions that remain unanswered before your dental treatment.

Thank you,

Joe McCreary, D.D.S.

Signature____ Date_____________________

Joe S. McCreary, D.D.S.
Notice of Privacy Practices

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 02/27/2003, 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 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.

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 or disclose your health information to obtain payment services.

Healthcare Operations**:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, licensing or credentialing activities.

Your Authorization**:** In addition to our use of your health information for treatment, payment of 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 we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends**:** We must disclose your health information to you, as described in the Patient Rights section of the 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 must use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal, 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 circumstance, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies etc.

Marketing**:** 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 of other crimes.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, Counterintelligence, and other national security activities. We may disclose to correctional institutions 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 (i.e. voicemail messages, postcards, etc.)

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 practically 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).

Disclosure Accounting**:** You have the right to receive a list of instances in which we disclosed you health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 1 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable fee for it.

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 so 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.
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 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 U.S. Department of Health and Human Services.

U.S Department of Health and Human Services
HIPAA Complaints
7500 Security Blvd.
C5-24-04
Baltimore, MD 21244

Contact Officer: Dr. Joe McCreary
209 Roe Street
Azle TX 76020
Telephone: 817-444-3209 Fax: 817-444-3200

I have received a copy of the Notice of Privacy Practices:

Please Print Name____

Signature____

Date________________________________

Release Form for Individuals Involved in Care of Patient

I, ______________________________give this office permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

This office may speak with:

Name: ____

Relationship: ____

Information to be released:
____Treatment ____Diagnosis ____Schedule ____Payment ____Other________

Name: ____

Relationship: ____

Information to be released:
____Treatment ____Diagnosis ____Schedule ____Payment ____Other________

Name: ____

Relationship: ____

Information to be released:
____Treatment ____Diagnosis ____Schedule ____Payment ____Other________

Name: ____

Relationship: ____

Information to be released:
____Treatment ____Diagnosis ____Schedule ____Payment ____Other________

Patient/Guardian Signature______________________________________

Date:____________________