## SECTION A: PATIENT GIVING CONSENT

Patient Name: ______________________________________________________________________________
Address:__________________________________________________________________________________
Telephone: ____________________________________________ Email: _____________________________________
DOB:_________________________________________________ SSN #: ______________________________________

## SECTION B: TO THE PATIENT – READ THE FOLLOWING STATEMENTS CARE FULLY.

**Purpose of consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read the Notice of Privacy Practice before you decide before whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operation, uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of out Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practice as described in our Notice Privacy Practices. IF we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of out Notice, at any time by contacting:

**Compliance Officer: Jennifer Castaneda**
**Telephone: 432-684-7424**
**Address: 2303 West Louisiana Ave, Midland Texas 79701**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

## SECTION C: SIGNATURE

I, __________________________________________ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature: _________________________________________________ Date:_____________________________________

If this Consent is signed by a personal representative (Parent/guardian) on behalf of the patient, complete the following:
Personal Representative's Name: _________________________________________________________________
Relationship to Patient: _______________________________________________________________________

## SECTION D: FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out 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 _____________________________________________________________________

Signature: __________________________________________________________ Date: ____________________________

You are entitled to a copy of this consent after you sign it.

# PRIVACY PRACTICES RECEIPT / CONSENT FORM

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**03/2021**

**SECTION E: REVOCATION OF CONSENT** ***only if it applies to you**

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operation.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ______________________________________________________________ Date: ____________________

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________________________ Date: __________________
Relationship to Patient: ____________________________________________________________________________

**SECTION F: PATIENT/RELATIVE HIPAA CONSENT** *** only if applies to you**

I, __________________________________________, understand that by signing this Consent form, I am giving my consent to John K. Drisdale III, DMD to disclose and discuss my protected health information to carry out treatment, payment activities and health care operation with the following family member:
Name: ______________________________________________________________________________________
Relationship: _________________________________________________________________________________

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

_____________________________________________________________ _________________________
Patient's Signature (Legal Guardian, if Patient is a minor) Date

**SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI)** ***only if it applies to you**

I requested that John K. Drisdale III, DMD. restrict the disclosure of my PHI to those specified below:

Name: ______________________________________________________________________________________
Name: ______________________________________________________________________________________

Signature: __________________________________________________________ Date: ________________________

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________________________________________________
Relationship to Patient: ____________________________________________________________________________

Last Name: ______________________________ First Name: ______________________________

Please Circle Marital Status: ___ **Single Married Divorced Separated Widowed Other**___________

Preferred Name: ______________________________ DOB: ______________________________

SSN: ______________________________ DL #: ______________________________

Address: ____________________________________________________________

City______________________________ State: ______________________ Zip: ___________

Cell: ______________________ Work: ______________________ Home: ______________________

Email: ____________________________________________________________

**If Married**: Spouse's Name: ______________________ DOB: ___________ Cell #: ________________

How did you hear about our practice: ______________________________________________

| **Primary Dental Insurance Information** | |
|---|---|
| Subscriber Name: ______________________________ | **Employer Name:** ______________________________ |
| Subscriber ID #: ______________________________ | **Insurance Company:** ______________________________ |
| Subscriber SSN: ______________________________ | **Group #:** ______________________________ |
| Date of Birth: ______________________________ | **Insurance Phone #:** ______________________________ |
| Relationship to Subscriber: ______________________________ | **We will file Primary Dental insurance ONLY** |

**Please present your insurance card and driver license to be scanned for our record**

**RESPONSIBLE PARTY (If Minor)**

Last Name: ______________________________ First: ______________________________

Address (if different): ______________________________________ DOB: ___________________

City: ______________________________ State: ___________________ Zip: ___________

Cell: ______________________ Work: ______________________ Home: ______________________

Email: ____________________________________________________________

**EMERGENCY CONTACT (Not in Same Household)**

Last Name: ______________________________ First: ______________________________

Phone #: ____________________________________________________________

**AUTHORIZATION** I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance.

______________________________________________ Date: ______________________________

Signature

○ Scanned

ROBERT E. CHRISTENSEN D.D.S.
JOHN K. DRISDALE D.M.D.

## DENTAL HISTORY

**Patient Name:**______________________________________________________

Reason for today's visit ______________________________________________Date of last dental visit_______________________

Former dentist ______________________________ Phone # ____________________ Date of last dental X-rays________________

**Please circle if you have/had:**

| | | | | |
|---|---|---|---|---|
| Bad Breath | **YES/NO** | Head, neck, jaw pain or aches | **YES/NO** | Have you ever had an allergic reaction to |
| Blister on lips or mouth | **YES/NO** | Lip or cheek biting | **YES/NO** | Novocain, local, or general anesthetics? |
| Burning sensation on tongue | **YES/NO** | Loose teeth or broken fillings | **YES/NO** | YES or NO |
| Chew on one side of mouth | **YES/NO** | Mouth breathing | **YES/NO** | IF Yes, please explain ___________________ |
| Cigarette, pipe , or cigar smoking | **YES/NO** | Orthodontic treatment | **YES/NO** | ______________________________ |
| Smokeless tobacco | **YES/NO** | Nitrous Oxide | **YES/NO** | ______________________________ |
| Dry mouth | **YES/NO** | Sensitivity to pressure or irritants | **YES/NO** | |
| Food collection between teeth | **YES/NO** | (cold, heat, sweets) | | Have you ever had trouble from previous |
| Clench or grind teeth | **YES/NO** | How often do you floss? ______________ | | Dental care? YES or NO |
| Growth or sore spots in your mouth | **YES/NO** | How often do you brush? _____________ | | **If yes, please explain:** _____________ |
| Gums swollen, tender or bleeding | **YES/NO** | | | ______________________________ |

Have you ever been diagnosed with Periodontal/Gum Disease? **YES/NO**

## MEDICAL HISTORY

Physician's Name: ______________________________________________Date of last visit: _________________________

Physician's Phone #: ________________________________________ Blood Pressure: ________________________________

Have you had any serious illnesses or operations? **YES or NO** if so, please describe ____________________________________

______________________________________________________________________________________________

Have you ever had a blood transfusion? ______________________________________________________________________

**(Women)** Are you pregnant? YES or NO Due Date: ________________ Nursing? **YES or NO** Taking Birth Control? **YES or NO**

**Please circle if you have/ had:**

**Have you tested positive for COVID-19? YES/NO If YES, When: ______________________________ TEMP: ____________**

**Have you received the COVID-19 Vaccination? YES/NO If YES, When:____________________________________________**

| | | | | | |
|---|---|---|---|---|---|
| Allergies, hay fever, sinusitis | **YES/NO** | Headaches | **YES/NO** | Slow healing wounds | **YES/NO** |
| Anemia | **YES/NO** | Heart murmur | **YES/NO** | Stroke | **YES/NO** |
| Arthritis, Rheumatism | **YES/NO** | Heart problems | **YES/NO** | Swelling of feet or ankles | **YES/NO** |
| Artificial heart valves | **YES/NO** | Hepatitis type______ | **YES/NO** | Thyroid problems | **YES/NO** |
| Artificial joints (see below) | **YES/NO** | Herpes | **YES/NO** | Tonsillitis | **YES/NO** |
| Asthma | **YES/NO** | High Blood Pressure | **YES/NO** | Tuberculosis | **YES/NO** |
| Required hospitalization | **YES/NO** | Any immune deficiency | **YES/NO** | Tumor or growth on head/neck | **YES/NO** |
| Date of last episode________________ | | Jaundice | **YES/NO** | Ulcer | **YES/NO** |
| Have you used steroids? | **YES/NO** | Kidney disease | **YES/NO** | Venereal Disease | **YES/NO** |
| Blood disease, clotting disorders | **YES/NO** | Low Blood Pressure | **YES/NO** | Weight loss, unexplained | **YES/NO** |
| Cancer | **YES/NO** | Mitral Valve Prolapse | **YES/NO** | Do you wear contact lenses? | **YES/NO** |
| Chemical dependency | **YES/NO** | Osteoporosis | **YES/NO** | Do you consume alcohol? | **YES/NO** |
| Chemotherapy | **YES/NO** | Osteopenia | **YES/NO** | Are you Allergic/sensitive to Latex? | **YES/NO** |
| Circulatory problem | **YES/NO** | Radiation treatments | **YES/NO** | Allergic to Penicillin, Aspirin, or any other drugs? | |
| Cortisone treatments | **YES/NO** | Respiratory disease | **YES/NO** | if Yes, please specify __________________ | |
| Cough, persistent or bloody | **YES/NO** | Rheumatic fever | **YES/NO** | ______________________________ | |
| Diabetes | **YES/NO** | Scarlet Fever | **YES/NO** | ______________________________ | |
| Emphysema | **YES/NO** | Shortness of breath | **YES/NO** | **Please list any medication that you are taking** | |
| Epilepsy | **YES/NO** | Sinus trouble | **YES/NO** | **(over the counter and Prescribed)** | |
| Fainting | **YES/NO** | Sickle cell anemia | **YES/NO** | **on the next page** | |
| Glaucoma | **YES/NO** | Skin rash | **YES/NO** | | |
| Blood thinning medications | **YES/NO** | History of Bisphosphonates | **YES/NO** | Infective Endocarditis | **YES/NO** |

**Do you need to Pre-Medicate for any dental cleanings/Treatment?** (reason_________________________________) **YES/NO**

If YES to Artificial joints: Which joint(s) and date of replacement(s) ________________________________________

## AUTHORIZATION AND RELEASE

**I have read and answered the above questions to the best of my knowledge.**

**Patient/Guardian Signature** ______________________________________________ **Date** ____________________

**Doctor Signature** ______________________________________________________**Date** ____________________

| Medications |
| --- |
| Please list ALL current medication<br>____________________________________________________________________________________<br>____________________________________________________________________________________<br>____________________________________________________________________________________<br>____________________________________________________________________________________<br>____________________________________________________________________________________<br>____________________________________________________________________________________<br><br>If you have a current medication list, we can copy that for you and attach to this form |

**Forms of payment available for treatment preformed.**

**Cash, debit, personal check and the following credit cards (MasterCard, Visa and Discover)**
**Care Credit**: We offer access to an outside financing company that provides a qualifying patient with an interest free loan for dental treatment. A short application is required and once the patient is approved, it is the patient's responsibility to pay all fees incurred to the financing company.

- **Payment for service is due at time treatment is render.**

Initial ____________________

**Dental Insurance:**
Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid with your policy: It coverage, exclusions, deductibles and maximums. We will recommend treatment appropriate to your dental needs, regardless of your insurance status. Our office is Out of Network with all insurance companies.

Our Courtesy service to our insured patients includes:
1. We will file the **Primary Dental insurance only**. We do not file secondary dental insurance, however we can provide any necessary claim forms and/or dental codes that may be needed.
2. Filing your claims promptly and requesting that payment be sent directly to us. Your Secondary payment will be sent directly to you after you file your claim.
3. Following American Dental Association guidelines for claims, coding and filing.
4. Estimating your benefits to best of our ability. Most insurance companies will not provide us with detailed information about your coverage, so any insurance figures we provide to you are only estimates.

Our expectations of you as the insured patient and/or owner of the policy:
1. You will pay to us all fee other than those estimated to be covered by your insurance company at the time of treatment.
2. You will assume responsibility for any amounts expected from your insurance company, but not received, within 30 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to you, and we have no leverage to obtain payment from your insurance company.
3. In the event the insurance company pay directly to you amounts that are owed to us, you agree to forward payment to us within 7 days after you receive it.

Initial ___________________

**Appointment cancellations without Notice:**
Consider your appointment with Dr. Drisdale as your personal reservation. And, as with all reservation you make, (such as airlines or hotel) there must be a cancellation policy.
1. As a courtesy to you, we will make every effort to confirm your reserved appointment. But, please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us at least 24 hours in advance to change or cancel your reserved appointment time.
2. All patients who fail to arrive for their reserved appointment or who cancel without 24 hour notice will be charged a missed appointment fee of $50. Please note that this missed appointment fee is NOT covered by insurance plans, and it is your responsibility to pay it. This fee will be waived only for unforeseen circumstances at Dr. Drisdale's discretions.

Initial __________________

We appreciate all of our patients, and it is not our intent to offend anyone. With your compliance, we will be more able to keep our schedule "on time" accommodates any emergencies, and help patients who are on our waiting list seek necessary treatment promptly. We thank you for your understanding in this matter.

I hereby authorize John K. Drisdale III, DMD to release to my insurance company and information acquired in the course of my dental care. I authorize benefits to be paid directly to John K. Drisdale III, DMD. I understand I am Responsible for all fee incurred, regardless of status of insurance and that payment is due at time of service rendered.

Responsible Party: ______________________________________________________________________________

Signature: ________________________________________________ Date: ____________________________________________

Witness (Staff Member):_____________________________________ Date: ____________________________________________