Hulen DENTAL
STOVALL • CHENG • THORBURN

Date: _____

Name: _____ Preferred Name _____ M ☐ F ☐ Date of Birth _____

Address: _____ Zip Code: _____

If child; Parent name: _____ Date of Birth _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Spouse's Name: _____ Date of Birth _____ Cell Phone: _____

Spouse's Occupation: _____ Employer: _____ Employer Phone: _____

Who referred you to our office? _____

Person responsible for dental investment: _____

For Insurance Purposes:

Name of Insurance Carrier: _____ Name of Insured: _____

Social Security Number or ID _____ Group Number: _____

Are you covered by another plan? ___ If so, Name of Carrier: _____

Name of Insured _____ Social Security Number or ID _____ Group Number: _____

Are your teeth sensitive to:	Yes	No
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any gum swelling around any teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Problems of the Jaw:		
Clicking of the jaw	☐	☐
Pain (joints, ear, side of face)	☐	☐
Difficulty opening or closing	☐	☐
Difficulty chewing	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐
Have you had a reaction to a local anesthetic?	☐	☐
Are you dissatisfied with your teeth & their appearance?	☐	☐
Are you deeply concerned about the finances required to return your teeth to excellent dental health?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you have any fears?	☐	☐
Have you ever had any teeth removed?	☐	☐
How long have these teeth been missing? _____		
Do you feel you will eventually wear artificial dentures?	☐	☐
When was your last dental appointment? _____		
Why did you leave your last dentist? _____		

	Yes	No
Do you have any general health problems?	☐	☐
If so, please specify: _____		
Have you had surgery?	☐	☐
If so, please specify: _____		
Are you currently under a physician's care?	☐	☐
Reason: _____		
Any Medications? _____		
Do you smoke?	☐	☐
To the best of your knowledge, are you or have you ever been afflicted with:		
Heart Ailment _____	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Epilepsy/Seizures	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease/Asthma	☐	☐
Hepatitis A, B, or C	☐	☐
HIV Positive	☐	☐
Prolonged Bleeding	☐	☐
Healing Complications	☐	☐
Allergy to any Drug/Latex/Metal	☐	☐
Artificial Joints (hip, knee, etc)	☐	☐
Are you Pregnant?	☐	☐

What is your present dental problem?

_____

The above personal, dental, and medical history is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatment. I will be presented options and allowed to ask questions. I take full responsibility for payment for all procedures during treatment regardless of dental insurance.

Signature: _____

SUBMIT

4900 Overton Ridge Blvd., Ste. 112
Fort Worth, TX 76132
Telephone (817) 292-5957
Fax (817) 292-0763

Notice of Privacy Practices

A copy of the Notice of Privacy Practices has been given to me and by signing below I acknowledge receipt of said notice.

Signature _____

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ **Patient refused to sign.**

_____ **Emergency situation kept us from obtaining the patient's signature.**

_____ **Language barriers kept us from obtaining the patient's signature.**

_____ **Other**

STOVALL & CHENG, D.D.S. PPLC

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 _____, 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.

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.

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, or 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 institution 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 (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. 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. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0._____ for each page. $_____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, for the last 6 years, 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 Web site 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.

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 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.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

_____

Submit

Hulen DENTAL
STOVALL • CHENG • THORBURN

4900 Overton Ridge Blvd., Suite 112
Fort Worth, Texas 76132
Telephone (817) 292-5957
Fax (817) 292-0763

Patient's Name _____ Name of Insured _____

Employer of Insured _____

Dental Insurance Information

Please help us serve you better when you visit our office for the first time. If you have dental insurance coverage, please call your insurance company IN ADVANCE of your visit. If there is no coverage, please disregard this request. Please ask the following important questions and write the information below. In all cases, we are a non- participating provider. We are NOT a DMO provider of any type. Keep in mind that insurance benefits are between you and your insurance carrier and you are ultimately responsible for the fees associated with treatment.

1. What is the effective date of the policy?
2. What is the annual deductible?
3. What is the annual maximum benefit?
4. What is the address and phone number of the insurance company?
5. What is your Identification and Group number for the policy?
6. Have any of your benefits been used? If so, what amount remains?

Please answer the following questions before you arrive for your visit. If at any time during treatment there is a change in your insurance information, it is your responsibility to inform our office. We kindly request that you bring both the completed insurance and new patient information forms with you to your first visit.

Thank you for your help in advance,

Leslie Anthony
Amy Brown
Administrators

SUBMIT