Evergreen Dental P.A.
225 E. State Hwy 121, Ste.117
Coppell TX 75019-2005

(972)315-0811
office@evergreendentaldfw.com
www.evergreendentaldfw.com

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Reason For This Visit:

_____

Whom may we thank for referring you to our practice?

- ☐ Dental Office
- ☐ Internet (Google) (Yahoo) (Other)
- ☐ Work
- ☐ Yellow Pages
- ☐ School
- ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Evergreen Dental P.A.
225 E. State Hwy 121, Ste.117
Coppell TX 75019-2005

(972)315-0811
office@evergreendentaldfw.com
www.evergreendentaldfw.com

Health Information

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

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ *See Meds
☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro
☐ Allergy - Hay Fever	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Blood Disease	☐ Cancer	☐ Diabetes
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur-NoPre-M
☐ Heart Murmur-Pre-Med	☐ Hepatitis	☐ High Blood Pressure	☐ HIV/AIDS
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Nervous Disorders	☐ Other	☐ Pacemaker	☐ Pregnancy Yr_____
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ STD	☐ Stomach Problems	☐ Stroke
☐ Thyroid	☐ Tuberculosis	☐ Tumors	☐ Ulcers

Please list ALL medications/supplements you are currently taking:

Have you ever had any complications following dental treatment? Y N

If Yes, Please explain:_____

Are you now under the care of a physician? Y N

If Yes, please explain:_____

Do you have any health problems that need further Clarification? Y N

If Yes, Please explain:_____

Evergreen Dental P.A.
225 E. State Hwy 121, Ste.117
Coppell TX 75019-2005

(972)315-0811
office@evergreendentaldfw.com
www.evergreendentaldfw.com

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment with out fail. CONSENT: I acknowledge that the Practice wil explain to me in specific terms the diagnosis of my condition, the basis for their Treatment Plan recommendations, specific descriptions of the proposed Treatment Plan, the alternatives (including non-treatment) and the risks and inconveniences. I will be given every opportunity to ask any questions and any such questions have been answered or explained to my satisfaction. By signing below, I acknowledge that I have been given time to read and have read the preceding information in this document and I agree to assume the risks and inconveniences of my treatment. I also agree that any and all disputes will be held between Members of 'the Practice' and me. Though occurring less than 1% of the time if there is a concern or expectation that was not realized I will do all in my Power to let the treating doctor remedy the situation and/or concern. No Third parties will be consulted and all issues will be dealt with directly with 'the Practice'. I consent to the production of records, including x-rays, photographs, prescriptions, and other information, which may include personal information before, during and after treatment (together, "Records"). The Practice may disclose my Records for treatment, payment, or healthcare operations, including disclosure to laboratories, other dental offices or professionals involved in my care, and to my insurance providers. I further agree that the photos taken are the property of Dr. Lee, 'The Practice' and they may be used for educational purposes, website use, lecturing, advertising, marketing and/or any and all office uses. These photos will be used with discretion, and may involve any part of the treatment phase. I understand this form and I consent to theTreatment Plan.

Signature: _____ Date: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Evergreen Dental P.A.
225 E. State Hwy 121, Ste.117
Coppell TX 75019-2005

(972)315-0811
office@evergreendentaldfw.com
www.evergreendentaldfw.com

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____ _____

_____ _____ _____

City State Zip Code

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ _____

Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

Evergreen Dental P.A.
225 E. State Hwy 121, Ste.117
Coppell TX 75019-2005

(972)315-0811
office@evergreendentaldfw.com
www.evergreendentaldfw.com

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. . I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental ins. understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of one month from the date of the patient examination.

In consideration for the services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

☐ I acknowlege that I have received a copy of HIPPA notice of privacy practices.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____

Evergreen Dental
Oral Rehabilitation Center

OFFICE POLICIES

We would like to welcome you to our office, and are happy you have chosen our office for your dental care. Our goal is to provide you with the best care available. In order to meet this goal, we need your assistance and understanding of our office policies.

INSURANCE COMPANIES

We are here to help answer any questions you may have regarding your dental insurance coverage and payments. However, your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy to you, our patient, we file your insurance for you. Even though we file your insurance for you, you are still financially responsible for the balance on your account. Your insurance company will pay what they feel is the going rate in our area, that may or may not be what our fees are, or they will pay according to the fee schedule that you are assigned to. The patient is responsible for any unpaid balance by your insurance company. If you have secondary insurance, we will be happy to provide you with the necessary information for you to file.

FINANCIAL RESPONSIBILITY

Full payment of services is due at the time services are rendered. If you have dental insurance, your estimated portion plus any deductibles will be due the day services are rendered. In the event that your insurance company does not cover your treatment or does not pay what is estimated from them, then you are responsible for any remaining balance in full. We accept cash, Visa, MasterCard and Discover. We also offer Care Credit for financing options. If you have any concerns with this policy, please let one of our staff members know.

MISSED APPOINTMENTS

We reserve time exclusively for you. We do not double-book our patients and thus insure the proper length of appointment time to render the ultimate care for our patients. Appointments missed or not cancelled within 48 WEEKDAY (Mon-Fri) hours are subject to a ***minimum*** **$50.00 charge**.

Thank you for choosing our office for your dental needs. We believe it is important that our patients fully understand our financial and office policies, so we may concentrate on you and your dental needs. It is your responsibility to notify us of any changes in your account status (i.e. change in address, work/home/cell numbers and/or insurance.) Please let us know if we can answer any questions.

I hereby certify that I have read and understand the previous information and I understand and agree to these policies. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____ _____

Signature of Patient or Guardian Date

225 E State Highway 121 Suite 117, Coppell, TX 75019
Tel: 972-315-0811 egdentaloffice@gmail.com Fax: 972-315-0891

HIPAA PRIVACY NOTICE

Effective April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

Introduction

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office.

Permitted Uses and Disclosures

We can use or disclose your protected health information for purposes of treatment, payment and health care operations.

- Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
- Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance carrier (or other third party payor) information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the carrier or other third party payor for the services rendered to you, we can provide the carrier or other third party payor with information regarding your care if necessary to obtain payment.
- Health Care Operations mean the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective.

Disclosures Related To Communications With You Or Your Family

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or relate specifically to your medical care through our office. For example, we may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the number that you have given us in order to contact you.

We may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care.

We will allow your family and friends to act on your behalf to pick up prescriptions, medical supplies, X-rays, and similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

Other Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report victim of abuse, neglect, or domestic violence
- To report reactions to medications
- To notify people of product, recalls, repairs or replacements
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in a response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement ♦ About a death we believe may be the result of a criminal conduct

- About criminal conduct on our premises
- In emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners and Funeral Directors. We may release medical information 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 release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disaster Relief. When permitted by law, we may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Your Rights

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request.
2. You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
3. Subject to payment of a reasonable copying charge as provided by state law, you have the right to inspect or obtain a copy of the protected health information contained in your medical and billing records and in any other practice records used by us to make decisions about you, except for:
   - Psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record
   - Information compiled in a reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
   - Protected health information involving laboratory tests when your access is required by law
   - If you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you
   - If we obtained or created protected health information as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research
   - Your protected health information is contained in records kept by a federal agency or contractor when your access is required by law
   - If the protected health information was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information

   We may also deny a request for access to protected health information if:
   - A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person
   - The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person
   - The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person

   If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.
4. You have the right to request a correction to your protected health information, but we may deny your request for correction, if we determine that the protected health information or record that is the subject of the request:
   - Was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment
   - Is not part of your medical or billing records
   - Is not available for inspection as set forth above
   - Is not accurate and complete

   In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.
5. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the period provided by law, except for disclosures:
   - To carry out treatment, payment and health care operations as provided above
   - To persons involved in your care or for other notification purposes as provided by law
   - For national security or intelligence purposes as provided by law
   - To correctional institutions or law enforcement officials as provided by law
   - That occurred prior to April 14, 2003
   - That are otherwise not required by law to be included in the accounting
6. You have the right to request and receive a paper copy of this notice from us.
7. The above rights may be exercised only by written communication to us. Any revocation or other modification of consent must be in writing delivered to us.

Complaints

If you believe that your privacy rights have been violated, you should immediately contact our Practice or our Privacy Officer. All complaints must be submitted in writing. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.