



Brent P. Robinson, DDS

Dear Patient,

We would like to welcome you to our office, and look forward to meeting you! We believe in utilizing the latest technology to provide our patients with the best in comprehensive, preventative dental care. Our philosophy is to maintain the excellent dental health of our patients and work to create a partnership to help you attain a healthy, attractive smile.

Our staff diligently strives to exceed the expectations of our patients and their families. Enclosed you will find a patient questionnaire and medical history form. These forms are important as they help to determine the course of your treatment. Your initial exam will take approximately one hour. It will include an exam of your teeth, gums, jaw alignment, and soft tissues. The exam also includes x-rays, a blood pressure check, and an oral cancer analysis.

We work very hard to control the cost of dental care. Prior to any work being performed, we will sit down together and go over our estimate of fees specific to your treatment plan.

Insurance helps with the cost of your dental care. Each policy is different. If you have insurance, we will file it for you. At each visit you will be expected to pay only the estimated percentage of your total fee—that portion not covered by insurance. When payment from the insurance company is received and applied to your account, any balance due will be billed to you, and any overpayment is refunded to you.

For our patients without insurance, we ask that you pay for services on the day they are completed. We accept Visa, MasterCard, and American Express. Financing options are also available through Care Credit.

If you are unable to make your appointment as scheduled, we require a 48 hour notice to avoid a cancellation fee of \$35.00. As a courtesy, we will call to remind you of your appointment 48 hours prior.

We look forward to meeting you, and serving your dental needs.

Very truly yours,

Brent P. Robinson, D.D.S.



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 (09/01/2002), 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 \$0.75 for each page, \$ 25 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: Brent Robinson D.D.S.

Telephone: 817-232-5341

Fax: 817-232-8785

E-mail: _____

Address: 825 Towne Ct., Saginaw, TX 76179

©2002AmericanDentalAssociation

All

Rights

Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.



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

(Please Print Name)

Signature

Date

If this consent is signed by a personal representative on behalf of the patient please complete the following:

Guardian/ Parent: _____ Relationship to Patient: _____

Please list the names of anyone (i.e. spouse/ child/ parent) whom you would like us to release any information regarding your dental/ medical records information. Medical Doctors, Pharmacies, and Insurance Companies excluded.

Name: _____

Name: _____

Name: _____

Name: _____

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our 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 practices as described in our Notice of 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 our Notice, at any time by contacting:

Contact Person: Kelly Grundy
Telephone: 817-232-5341 Fax: 817-232-8785
Address: 825 Towne Ct., Saginaw, TX 76179

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 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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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 on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

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: _____

2002 ADA All Rights Reserved

WELCOME - NEW PATIENT

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

PATIENT
NAME

About You...

This information is necessary for our records. It is considered strictly confidential. Please complete all parts.

NAME _____ MR. MRS. MS. DR.
LAST FIRST MI

I prefer to be called _____ MALE FEMALE

BIRTHDATE _____ AGE _____ SS# _____

HOME ADDRESS _____

E-Mail Address: _____

Single Married Divorced Widowed Separated

HOME # _____ PAGER / OTHER # _____

WORK # _____ EXT. _____ DL# _____

EMPLOYER _____ HOW LONG THERE? _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us _____

Person Responsible for Account...

NAME _____ ADDRESS _____

EMPLOYER _____ WORK # _____

SS# _____ BIRTHDATE _____ DL # _____

Insurance...

We file insurance as a courtesy.

Insurance is not meant to pay your entire balance. We have found insurance pays about 50% to 80% of treatment. Your insurance company has no obligation to us, only to you, the policyholder. If you have any grievance, please file it with your union carrier.

Regardless of any insurance you might have, please remember, the PATIENT is personally responsible FOR THE PAYMENT IN FULL FOR SERVICE.

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday _____ Insured's SS# _____

Insured's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____ Relation _____

Insured's Birthday _____ Insured's SS# _____

Insured's Employer _____

Misc.

Do you have a personal physician? Yes No

Medical Physician's Name _____

Physician's Phone _____ Date of last visit _____

Emergency Information: Please list the names and telephone numbers of two relatives (or friends) *not living with you* that we may contact in the case of an emergency.

Name _____ Relation _____ Name _____ Relation _____

Address _____ Address _____

Phone # _____ Phone # _____

Blue Sky Smiles

MEDICAL HISTORY

Patient Name _____ Birth Date _____

Email Address _____ Phone Number _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? YES NO If yes, please explain: _____

Have you ever been hospitalized or had a major operations? YES NO If yes, please explain: _____

Have you ever had a serious head or neck injury? YES NO If yes, please explain: _____

Are you taking any medications, pills, or drugs? YES NO If yes, please explain: PLEASE LIST ALL MEDICATIONS AND DOSAGES IN THE COMMENT SECTION

Do you take, or have you taken, Phen-Fen or Redux? YES NO _____

Are you on a special diet? YES NO _____

Do you use tobacco? YES NO _____

Do you use controlled substances? YES NO

Women: Are you Pregnant/Trying to get pregnant? YES NO Taking oral contraceptives? YES NO Nursing? YES NO

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease/Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever had any serious illness not listed above? YES NO If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____