

**Personal History**

*Welcome! We appreciate the opportunity to provide you with dental services. So that we can know you better, please fill out the following information. Your past medical history can be of great importance to your dental treatment. Full and accurate disclosure is an important safeguard to your health.*

**Social Security No.** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Driver's License (D.L.)** \_\_\_\_\_ **D.L. State:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Spouse:** \_\_\_\_\_ **Spouse Cell:** \_\_\_\_\_

**Spouse Email:** \_\_\_\_\_ **Spouse Employer:** \_\_\_\_\_

**Name of Physician, (M.D.):** \_\_\_\_\_ **Physician #:** \_\_\_\_\_

**Medications you are now taking:** \_\_\_\_\_

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**Emergency Contact:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Name of nearest relative not living with you:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

**I hereby authorize Dr. Corbet C. Locke, to use any x-rays, study casts, photos, or videotapes for educational and teaching purposes.**

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HEALTH HISTORY

### Have you ever had or suspected?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Mitral Valve prolapsed	_____	_____	Hepatitis/Jaundice	_____	_____
Heart Murmur	_____	_____	Nervous Disorders	_____	_____
Rheumatic Fever	_____	_____	Severe Headaches	_____	_____
Heart Trouble	_____	_____			
If yes, please list: _____			Epilepsy/Convulsions	_____	_____
Abnormal Blood pressure	_____	_____	Fainting	_____	_____
Chest pains	_____	_____	Recent Weight Loss	_____	_____
Shortness of Breath	_____	_____	Recent Weight Gain	_____	_____
Swollen Ankles	_____	_____	Liver problem	_____	_____
Asthma	_____	_____	Kidney/Bladder Problem	_____	_____
Ear Aches	_____	_____	Arthritis	_____	_____
Respiratory Problems	_____	_____	Prosthetic/Artificial Joints	_____	_____
Tuberculosis	_____	_____	Cancer or Tumors	_____	_____
Diabetes	_____	_____	Radiation Treatment	_____	_____
Thyroid Disease	_____	_____	Glaucoma	_____	_____
Anemia/Blood Disorders	_____	_____	Recent Medical Surgery	_____	_____
Bleeding Disorders	_____	_____	Have you ever had a drug or alcohol problem?	_____	_____
Prolonged bleeding from cut or extraction?	_____	_____	Do you smoke or use any type of tobacco products?	_____	_____
AIDS	_____	_____			

### Have you ever taken?

Cortisone, Steroids	_____	_____
Anticoagulants (blood thinners)	_____	_____

### Are you Allergic to?

Penicillin	_____	_____
Allergic to any other medications?	_____	_____
If yes, please list:	_____	

### Please Circle One:

Have you ever been told you have osteoporosis or low bone density	Y	N
Have you ever had Bisphosphonate Therapy (i.e., Zometa, Fosamax, Aredia, & Boniva)?	Y	N
Do you snore?	Y	N
Has your snoring ever woken you up?	Y	N
Do you ever gasp or choke in your sleep?	Y	N
Have you ever been diagnosed with sleep apnea?	Y	N
Do you ever wake up with headaches in the morning?	Y	N

### Women Only:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Are you Pregnant?	_____	_____	Breast feeding?	_____	_____

# ADA American Dental Association® Dental Claim Form

## HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services       Request for Predetermination/Preauthorization  
 EPSDT / Title XIX

2. Predetermination/Preauthorization Number

## INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

## OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental?  Medical?  (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)      7. Gender  M  F      8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number      10. Patient's Relationship to Person named in #5  
 Self    Spouse    Dependent    Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

## POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)      14. Gender  M  F      15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number      17. Employer Name

## PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above  
 Self    Spouse    Dependent Child    Other      19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)      22. Gender  M  F      23. Patient ID/Account # (Assigned by Dentist)

## RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16  
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier  (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s)      A \_\_\_\_\_      C \_\_\_\_\_  
 (Primary diagnosis in "A")      B \_\_\_\_\_      D \_\_\_\_\_

31a. Other Fee(s)

32. Total Fee

35. Remarks

## AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X \_\_\_\_\_  
 Patient/Guardian Signature      Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X \_\_\_\_\_  
 Subscriber Signature      Date

## BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI      50. License Number      51. SSN or TIN

52. Phone Number      52a. Additional Provider ID

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment  (e.g. 11=office; 22=O/P Hospital)      39. Enclosures (Y or N)   
 (Use "Place of Service Codes for Professional Claims")

40. Is Treatment for Orthodontics?  
 No (Skip 41-42)    Yes (Complete 41-42)      41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment      43. Replacement of Prosthesis  No  Yes (Complete 44)      44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  
 Occupational illness/injury    Auto accident    Other accident

46. Date of Accident (MM/DD/CCYY)      47. Auto Accident State

## TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X \_\_\_\_\_  
 Signed (Treating Dentist)      Date

54. NPI      55. License Number

56. Address, City, State, Zip Code      56a. Provider Specialty Code

57. Phone Number      58. Additional Provider ID



# Corbet Locke DDS

## Notice of Privacy Practices

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

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

**Our Privacy Officer is Jim Moore - 469.342.8300, Extension 508**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **A. Uses and Disclosures of Protected Health Information**

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

#### **Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent**

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses. We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may request that these materials not be sent to you.

### **Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object**

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

## **Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## **B. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limits.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

### **C. Complaints**

You may complain to us, to the Texas Attorney General's Office, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Jim Moore, a Certified HIPAA Professional. You may contact our Privacy Officer in writing at our office address or by calling 469.342.8300, Extension 508. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on November 10, 2016.





# Corbet Locke DDS

## Acknowledgement of Receipt Consent to Use and Disclosure of Protected Health Information

### Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

### Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

### Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

### Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

**By my signature below I give permission to use and disclose my health information.**

Patient or Legally Authorized Individual Signature

Date

Time

Print Patient's Full Name

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### Witness Signature

Date

Time