Cheryl E. Davis, DMD, PLLC
210 Chestnut Street
San Antonio, TX 78202

(210) 212-8707

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone # (___) _____ Cell Phone #1 (___) _____ Cell Phone #2 (___) _____

Employer _____ Employer Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (___) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (___) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (___) _____

Birthdate _____ Currently a patient in our office? ☐Yes ☐No

Employer _____ Work Phone (___) _____

E-Mail _____ Cell Phone (___) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # (___) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # (___) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

All responses are kept confidential

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health? ..... Y N
2. Has there been any change in your general health in the past year? ..... Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? ..... Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: ..... Y N

_____

_____

6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? .... Y N
   - B. Congenital Heart Disease? ..... Y N
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) ..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness ..... Y N
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? ..... Y N
   - G. Liver Disease (Jaundice, Hepatitis)? ..... Y N
   - H. Kidney Disease? ..... Y N
   - I. Diabetes? ..... Y N
   - J. Thyroid Disease (Goiter)? ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Osteoporosis ..... Y N
   - O. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? ..... Y N
   - O. Radiation (X-ray) treatment for Cancer? ..... Y N
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? ..... Y N
   - Q. Sinus or Nasal problems? ..... Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system? ..... Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? ..... Y N
   - B. Anticoagulants (Blood Thinners)? ..... Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
   - D. High Blood Pressure medications? ..... Y N
   - E. Steroids (Cortisone, etc.)? ..... Y N
   - F. Tranquilizers ..... Y N
   - G. Insulin or Oral Anti-Diabetic drugs? ..... Y N
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
   - I. Are you taking or ***have you ever taken*** Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa) ? ..... Y N
   - J. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____

_____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? ..... Y N
   - B. Penicillin or other antibiotics? ..... Y N
   - C. Sedatives, Barbiturates? ..... Y N
   - D. Aspirin or Ibuprofen? ..... Y N
   - E. Codeine or other pain killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Other allergies or reactions? Please, list. ..... Y N

_____

_____
10. Do you smoke or chew Tobacco? ..... Y N
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? ..... Y N
12. Have you had any serious problems associated with any previous dental treatment? ..... Y N
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? ..... Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? ..... Y N
15. Do you wish to talk to the doctor privately about anything? ..... Y N
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or <u>Is there any chance</u> you might be Pregnant? ..... Y N
    - B. Are you nursing? ..... Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Doctor's Initials _____

Medical Update: I have ready my Health History dated _____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

Date _____ Exceptions or changes _____ Patient's Signature _____ Doctor's Initials _____

IMPORTANT INFORMATION FOR PATIENTS USING ORAL CONTRACEPTIVES

Patient's Name _____ Date _____

It has been explained to me, and I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control for one complete cycle of birth control pills after the course of antibiotics or other medications is completed.

Patient's (or Legal Guardian's) Signature _____ Date _____

Doctor's Signature _____ Date _____

Witness' Signature _____ Date _____

FOR WOMEN ONLY

Cheryl E. Davis, D.M.D
Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____
Address:_____
Telephone:_____ E-mail:_____
Patient's #:_____ Social Security #:_____

SECTION B: 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 conduct treatment, pay activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sigh 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 other important matters about your protected health information. A copy of our NOTICE accompanies this CONSENT. We encourage you to read 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: Cheryl E. Davis DMD/Manager
Telephone: (210) 212-8707 Fax: (210) 212-8780
E-mail: cheryldavis.dmd@sbcglobal.net
Address: 210 Chestnut Street, San Antonio, Texas 78202

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.

SECTION C: SIGNATURE

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 conduct treatment, payment activities and health care operations.

Signature:_____ Date:_____

Consent form signed by a personal representative on behalf of the patient
Personal Representative's Name:_____ Relationship:_____
Signature:_____

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

Financial Policy

Thank you for choosing Cheryl E. Davis, DMD, Family Dentistry. We are committed to the success of your treatment.

The following is a statement of our Financial Policy that we require to read and sign prior to treatment.

Uninsured Patients: Full payment is due on the day of treatment.

A procedure requiring more than one visit for example: crowns, bridges, dentures, partials, and multiple extractions. Refer to our payment options.

Insured Patients: Based on the information from your insurance company, we estimate cost to best of our ability, what your cost share will be. The estimated cost share or co-pay is due the same day service is rendered. Any remaining balance after your insurance company has made their final payment will be your responsibility to pay.

When you sign this statement, you agree to pay any remaining balance on your account not covered by your insurance company.

Minor Patients: Minors under 16 years of age will be seen only when accompanied by parent or legal guardian. Prior payment arrangement must be made for minors 16—18 years of age receiving treatment unaccompanied by their responsible party.

Broken Appointments: We require a 24-hour notification for cancelled appointments. We will charge a fee of $10.00 per scheduled hour for broken appointments or appointments cancelled without a 24 hour notice.

A 1.5 monthly charge or a service charge of $25.00 is applied to balance over 30 days after insurance settlement. Accounts in errors over 90 days are sent to collections and the patient/responsible party will be liable for all collection and/or attorney fees. Returned checks due to insufficient fund will incur a $35.00 fee.

WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD

Thank you for understanding our Financial Policy. Please feel free to talk with us regarding any questions or concerns you may have. We look forward to being you dental care provider.

I have read, understand and agree to the provisions of this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

Cheryl E. Davis, DMD
Family Dentistry
210 CHESTNUT STREET
SAN ANTONIO, TEXAS 78202
OFFICE: (210) 212-8707 FAX: (210) 212-8780

PAYMENT OPTIONS

In an effort to provide you with flexible payment arrangements we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

☐ ***Payment in Full***
- __ Payment by cash
- __ Payment by check
- __ Payment by credit card

☐ ***Office Payment Plan***
- Extensive Procedures requiring multiple visits
- Initial procedure will require 1 Payment followed by 3 monthly payments of postdated checks.

_____I hereby authorize and direct payment benefits otherwise payable to me, directly to the Above name dentist or dental entity

If none of the above applies, please see the office manager. Thank you.

_____
Print your name here and sign below

*X*_____
Date: _____

FACTS ABOUT INFECTION CONTROL IN OUR OFFICE

The Infection control guidelines established by the American Dental Association (ADA), Center for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA) are used to prevent disease transmission in the dental office.

1. A thorough evaluation of Medical History.

2. Use of Personal Protective Equipment (PPE)
   - Gloves are worn when touching blood, saliva and mucous membranes (mouth, gums, cheeks, etc).
   - Surgical masks and protective eyewear are worn to protect from bodily fluids (saliva and blood).
   - Reusable or disposable gowns, laboratory coats, and uniforms are worn during patient care.
   - Barriers (plastic or aluminum) are used to cover surfaces such as light handles, x-ray unit heads etc.

3. Hands are thoroughly washed between patient treatment contact.

4. Sterilization
   - Dental hand instruments and handpieces are cleaned and then sterilized by an autoclave, dry heat or chemical vapor.
   - Periodic spore testing devices are used to verify the sterilization cycle.

5. Decontamination
   - Dental chairs, lead aprons, countertops and surfaces contaminated with blood or saliva will be wiped down with a chemical germicide.

These safety measures are instituted to eliminate transmission of diseases such as:

- Hepatitis
- Herpes
- Tuberculosis (TB)
- AIDS
- Respiratory Diseases (common cold)

There are costs involved to maintain our high standards of infection control.

Presently this fee is not covered by the insurance company.

- It is anticipated that the insurance company will cover the fee in the future.

If you have any questions, please feel free to discuss our infection control procedures and costs with our staff.

HIPAA Notice of Privacy Practices

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Family Dentistry
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY

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

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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, to pay health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students 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 physician. We may also call you by name in the waiting room when your dentist 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 may also mail postcards to remind you of upcoming appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required by Law, Public Health issues as required bye law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: 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 requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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.

You have the right to request a restriction of your protected health information. This means you may ask us not to use of disclose any part of your protected health information for the purpose 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 the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician 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. You than have the right to use another Healthcare Professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file as 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us 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 notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals, with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____