

Patient Information

Patient Name _____ Social security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Patient Employer _____ Age _____ D.O.B. _____ Marital Status _____ Driver's Lic# _____

Bus # _____ Mobile # _____ Pager # _____ E-mail _____

Name and # of emergency contact person _____ Relationship _____

How did you find out about our office? _____

Insurance Information (please fill out completely)

Person responsible for account _____ Relationship to patient _____

Address (if different) _____ City _____ State _____ Zip _____

Home # _____ Bus # _____ Mobile # _____ Driver's Lic# _____

Birthdate _____ Social Security # _____ Subscriber Employer _____

Insurance Company _____ Group # _____ Phone # _____

Insurance Company Address _____

Dental History

Last Dental Visit _____ Past major dental treatment _____

How often do you brush? _____ How often do you floss? _____

What did you like most about your former dental office? _____

What do you like least about going to the dentist? _____

Please place a check mark next to any dental problem that you are experiencing.

Bleeding Gums

Grinding Teeth

Sensitivity to Hot

Sores in Mouth

Jaw Pain

Sensitivity to Cold

Bad Breath

Broken Fillings

Sensitivity to Biting

Receding Gums

Loose Teeth

Sensitivity to Sweets

Do you like your smile? _____ Would you like whiter teeth? _____ Are you interested in a cosmetic consultation? _____

If you had a magic wand, what would you change about your smile/teeth? _____

Medical History

Patient Name _____ Date _____

Medical Doctor's Name _____ Phone # _____

Please describe any serious illness or any operations you have or have had _____

Please place a check mark next to any condition below that you have now or have *ever* had in the past.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Habit |
| | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Venereal Disease |

Please place a check mark next to any condition that you *currently* have.

- | | | |
|---|--|--|
| <input type="checkbox"/> <u>Cardiovascular Disease</u> | <input type="checkbox"/> <u>Respiratory Disease</u> | <input type="checkbox"/> <u>Gastrointestinal Disease</u> |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough | <input type="checkbox"/> Sudden Weight Loss or Gain |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Edema (swelling of legs or ankles) | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Change in Bowel Habits |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Unexplained Vomiting |
| <input type="checkbox"/> <u>Genitourinary Disease</u> | <input type="checkbox"/> <u>Neurological Disease</u> | <input type="checkbox"/> <u>Musculoskeletal Disease</u> |
| <input type="checkbox"/> Pain During Urination | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Joints |
| <input type="checkbox"/> Frequent Nighttime Urination | <input type="checkbox"/> Seizures | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Swelling in Joints |
| <input type="checkbox"/> Constant feeling of Urination | <input type="checkbox"/> Weakness/Tingling/Numbness | <input type="checkbox"/> Arthritis |
| | <input type="checkbox"/> Difficulty in Urination | <input type="checkbox"/> Loss of Coordination |

Do you have any allergies to any medications? If so, which ones? _____

Does skin react to any type of jewelry, metals or latex? _____

Explain your allergic reaction to these medications. _____

Please list any medications that you are currently taking and for what conditions, including over-the-counter drugs, and the dosage if known _____

Do you have any other medical condition that has not been covered above? If so, please discuss with the doctor.

The medical history described above is complete to the best of my knowledge.

Signature of Patient or Guardian _____ Date _____

Mark Kupec D.D.S., P.C.

Our Service Agreement

Dear Patient,

We appreciate you choosing our office as your dental health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask for our assistance.

We ask that **all** patients read and sign our Financial Policy as well as complete our Patient Information Form Prior to seeing the doctor.

Payments for services are due at the time of treatment. We accept cash, checks, and for your convenience, Visa, Mastercard, Discover and Care Credit. For patients who are children of divorce, the parent or guardian who brings the child to the appointment is responsible for payment.

As a **courtesy** to our patients, we will gladly file your insurance claims as long as we have the most current insurance information.

By signing below, you authorize Mark Kupec, DDS, and PC to accept **1. Assignment of Primary Insurance** and **2. Release of Information** as necessary requirements to process your claim as outlined by your insurance policy. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are **Not** a party to that contract. Our relationship is with you alone.
2. All charges are your responsibility whether your insurance company chooses to pay or not. Not all services are covered benefits in all contracts. Some insurance companies pick and choose which services they will cover.
3. All estimated charges along with unpaid deductibles are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 60 days of date of service, we require you to pay the balance with cash, check or credit card.
5. Returned checks are subject to a \$35 charge.
6. Balances older than 60 days may be sent to an outside collection agency.
7. We do not accept payment from any secondary insurance carrier.

If you are unable to keep any appointment, please give us 1 business day (Mon.- Thurs.) notice so the time that we reserved for you can be made available to treat another patient who is in need. We reserve the right to charge a missed appointment fee for appointments missed without adequate notice.

Any appointment 1.5 hours long or longer will require a deposit of 20%. The deposit will be applied to the appointment unless the appointment is missed without adequate notice.

We understand that temporary financial problems may affect timely payment. Therefore, we encourage you to communicate any such problems so that we can assist you in the management of your account. **However, if your account becomes past due (after 30 days from the date of service), we will take all the necessary steps to collect the debt. If we have to refer your account to a collection agency, you agree to pay all the collection fees that are incurred.**

We appreciate your trust in us and hope to provide you with the ultimate care you deserve.

Patient/Guardian Address _____

Patient/Guardian Signature _____ Date _____

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, audit functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such written authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Dr. Kupec, the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information. Cost of copying dental records are \$30 that include the first 10 pages, \$1 for pages 11-60, \$.50 for pages 61-400 and \$.25 for remaining pages, and actual costs of mailing/shipping. Costs of x-ray duplication are \$15 for full mouth series or panoramic x-rays, \$10 for bitewing x-rays, and \$5 for single x-rays.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have a right to file a written complaint with our office; if the complaint is not resolved within our office you may forward the complaint to: Region VI, Office of Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, TX 75202. Phone (214) 767-4056; Fax (214) 767-0432; TDD (telecommunications Display Device) (214) 767-8940.

Mark Kupec D.D.S
Family and Cosmetic Dentistry
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Georgetown, TX 78628
(512) 600-7645

Acknowledgement Of Receipt Of Notice Of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Print name

Signature

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____ Patient refused to sign

_____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Describe below)