WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Business Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D. # _____ Group # _____

Please complete reverse side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐
Please describe: _____		
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

- AIDS ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Chronic Fatigue Syndrome ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough - persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or Dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis-Type _____ ☐
- Herpes ☐
- High Blood Pressure ☐
- HIV Positive ☐
- Jaundice ☐
- Jaw Pain ☐
- Latex Sensitivity ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervous Problems ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Stroke ☐
- Swelling of Feet/Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head/neck ☐
- Ulcer ☐
- Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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!

With your consent, the practice is permitted by federal privacy laws to make use and disclosures of tour health information for purpose of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

EXAMPLE OF USES OF YOUR HEALTH INFORMATION FOR TREATMENT PURPOSES:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

EXAMPLE OF USE OF YOUR HEALTH INFORMATION FOR PAYMENT PURPOSE:

We obtain services from our insures or other business associates such as quality assessment, quality improvements, out come evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associated as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosure of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record..you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protested health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain and accounting of disclosure of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal used of information for treatment, payment, or operations, disclosures

made to you or made at your request, or disclosures made to family members or friends in the course of provide care;

- Request that communication that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contract DAVID LAING DDS in person or in writing, during normal hours. He will provide you with assistance on steps to take to exercise your rights.

OUR RESPONSIBILITIES

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practice as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable request methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practice and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have any questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact DAVID LAING DDS, **22108 Seven Meadows Pkwy, Suite 200, Katy, Texas 77494; (281)6930475.**

Additionally, if you believe tour privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to DAVID LAING DDS. You may also file complaint by mailing it or e-mailing it to the Secretary of Health and Human Service.

- We cannot, and will not, require you to waive your rights to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filling a complaint with the Secretary.

OTHER DISCLOSURES AND USES

Notifications

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your case about your location, and about general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Worker's Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers compensation.

Public Health

Required by law, we may disclose your protected health information to the public or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law Enforcement

We may disclose your protected health information for law enforcement purpose as required by law, such as when required by a court order, or in a case involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight authorities or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose tour protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures beside those identified in this Notice will be made only as otherwise authorized by law or with your written consent, or as directed by a proper court order.

Website

If we maintain a website that provides information about our entity, the Notice will be on the website.

I,_____ ,hereby acknowledge that I have received a copy of the practice' Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Name Date

SEVEN MEADOWS DENTAL
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for SEVEN MEADOW DENTAL to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practice prior to signing this consent. SEVEN MEADOWS DENTAL reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to SEVEN MEADOWS DENTAL at 21108 SEVEN MEADOWS PKWY, Suite 200 Katy, TX 77494.

With this consent, SEVEN MEADOWS DENTAL may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked " Personal and Confidential".

With this consent, SEVEN MEADOWS DENTAL may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request the SEVEN MEADOWS DENTAL restrict how it uses of discloses my PHI to care out TPO. The Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow SEVEN MEADOWS DENTAL to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, SEVEN MEADOWS DENTAL may decline to provide treatment to me.

_____

Signature of Patient of Legal Guardian

_____ _____

Print Patient's Name Date

SEVEN MEADOWS DENTAL FINANCIAL POLICY

Thank you for choosing SEVEN MEADOWS DENTAL as your dental care provider. Our office is committed to providing you with the best possible care. Then following is a statement of our financial Policy which we require you to read and sign prior to any treatment.

REGARDING PAYMENT

We accept the following forms of payment: Cash, Check, Visa, Master Card, American express and Care Credit.

Payments for services are due at the time services are rendered unless prior arrangements have been made with the billing receptionist.

If Crowns, Bridges, Partials or Dentures are to be fabricated by a dental laboratory, 50% of the bill is to be paid at the time of the first impression. The remaining balance is due at the time Crown, bridge, Partials or Dentures is cemented or delivered.

The parent that accompanies minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized before the appointment date or previous arrangements have been made with the billing receptionist.

REGARDING INSURANCE

All insurance co-pays and deductibles must be paid at the time of service. If you have any changes to your insurance company please let us know as soon as possible.

We are glad to assist you in obtaining maximum benefits from your Dental Insurance Plan. However, your instance policy is a contract between you and your insurance company. We are not a party to that contract. The benefits your plan pays are largely determined by how much your employer pays in premiums for that plan. The less they pay for the plan the less you'll receive.

We will do our best to estimate what your insurance will pay. However, many plans have exclusions and limitations which will affect your out-of-pocket expense. We are happy to submit the claim for you, but please understand that we cannot accept responsibility for collecting your insurance claim, or for negotiating disputed claims. If your dental insurance company payment is not received in 75 days after date of service, the entire balance is due from you. You can the obtain reimbursement directly from your insurance company.

I have read SEVEN MEADOWS DENTAL FINANCIAL POLICY; I understand and agree to the policy.

Signature if Patient or Responsible Party:_____ Date:_____

Print name of Patient or Responsible Party:_____