MIRA VISTA DENTAL ASSOCIATES

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single Married Divorced Widowed

Nickname:	Driver's License:	Social Security No:	Birth date:	Age:	Sex:
					❑ M ❑ F

Street address:	Apartment #:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Employer:	Occupation:	Employer phone no.: ( )

Employer's Address:

Email address for appointment reminders:	Cell phone no.: ( )

Who may we thank for referring you:

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No Relation to Subscriber: ❑ Self ❑ Spouse ❑ Child

Subscriber's Name:	Subscribers SSN:	Subscribers DOB:

Insurance Company Name:	Insurance Company Phone #

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no: ( )	Work phone no: ( )

Insurance Billing, Charges and Acknowledgement of Receipt of Privacy Practices

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize Mira Vista Dental Associates or insurance company to release any information required to process my claims. I authorize Mira Vista Dental Associated to contact me via email. I have received a copy of this office's Notice of Privacy Practices.

Patient/Guardian signature *Date*

HEALTH HISTORY QUESTIONNAIRE

Name	☐ M ☐ F	**DOB:**

PERSONAL HEALTH HISTORY

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Abnormal Blood Pressure	☐ Diabetes	☐ Arthritis
☐ Heart Attack	☐ Epilepsy	☐ Liver Disease
☐ Heart Surgery	☐ Tuberculosis	☐ Hepatitis
☐ Heart Murmur	☐ Lung Disease	☐ Sleep Apnea
☐ Congenital Heart Lesions	☐ Gastric Ulcers	☐ Artificial Joints or Implants
☐ Artificial Heart Valve	☐ Sinus Trouble	Date _________
☐ Pacemaker Date ____________	☐ Allergies, Allergies	☐ Cancer
☐ Congestive Heart Disease	☐ Popping Clicking in Jaw	☐ Hemophilia
☐ Stroke	☐ Headaches	☐ HIV
☐ Anemia	☐ Glaucoma	☐ Pain, discomfort
☐ Rheumatic Fever	☐ Kidney Disease	☐ Other
☐ Circulation Problems	☐ Thyroid Disease	

PLEASE EXPLAIN ANY OF THE ABOVE

Condition	**Explanation**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

Are you allergic to latex?	☐ Yes	☐ No

HEALTH HABITS

Bisphosphonates	These medications include: Aredia, Zometia, Fosamax, Actonel, Boniva				
	Have you ever taken or are you currently taking these medications?			☐ Yes	☐ No
	☐ By mouth	☐ By IV			
Beverages	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit			

WOMEN ONLY

Are you pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No

ATTESTATION

The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*

Notes of Dr. Greg Ellis:

ATTESTATION

I have reviewed the health history and discussed findings with the patient.

Dr. Greg Ellis' signature *Date*

Greg Ellis D.D.S.

Gregellisdds.com
817-370-7776

We are happy to prepare any insurance claim as a service to you at no charge.. Please note that we do not guarantee insurance reimbursement outcomes. While we attempt to maximize your reimbursement, you are responsible for all fees in their entirety, regardless of the amount of your insurance coverage.

A few notes about insurance:

Dental insurance companies do not normally cover 100% of any dental fee and often cover less than 50%. Sometimes no payment is made. The fine print of your plan reveals the truth about actual percentages, which can be less than expected.

Estimated benefits are subject to your coverage being in force at the time services are preformed and are subject to the specific limitations and exclusions listed in your benefit plan.

Your insurance plan is based upon a contract between your employer and the insurance company. The dollar amount of reimbursement for dental services is determined by how much your employer has paid for the plan. We will complete your dental insurance claim form to achieve the maximum reimbursement to which you are entitled. While insurance premiums have increased, benefits have decreased.

Dental insurance is not designed to pay for your complete dental care. Routine and newer services are sometimes not covered. Our goal is to help you achieve and maintain optimal dental care. If you have any questions regarding the specifics of your dental insurance plan, please contact your employer or insurance company directly.

Signed ______________________________________ Date ______________

Greg Ellis D.D.S.

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Mira Vista Dental Associates

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 uses and disclosures of your health information for purposes 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 or 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 purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome 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 associates 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 a right to:

- Request a restriction on certain uses and disclosures 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 protected 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 an accounting of disclosures 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 uses 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 providing care;
- Request 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; and,
- 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 contact **Greg Ellis at 817-370-7776,** in person or in writing, during normal hours. He will provide you with assistance on the 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 practices 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 requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices 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 questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Greg Ellis at 817-370-7776.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Greg Ellis.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right 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 filing a complaint with the Secretary.

OTHER DISCLOSURES AND USES

Notification
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 care, about your location, and about your 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 in 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 relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

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

Public Health
As required by law, we may disclose your protected health information to public health 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.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases 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 agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your 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 besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.