



**PATIENT INFORMATION**

Date \_\_\_\_\_  
Home Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

*PERSONAL INFORMATION*

*SPOUSE / PARENT INFORMATION*

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_  
Employer \_\_\_\_\_  
Business Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Position \_\_\_\_\_  
Social Security # \_\_\_\_\_

Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Business Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Position \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Birth date \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU / HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

*GENERAL INFORMATION*

Convenient appointment time \_\_\_\_\_  
Are you available for appointments on short notice? \_\_\_\_\_  
Person to contact for emergency \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Their telephone # \_\_\_\_\_  
Nearest Relative Not Living With You \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Person responsible for account \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Bank \_\_\_\_\_ Branch \_\_\_\_\_

*If you have dental insurance, please fill in the following:*

**PRIMARY CARRIER**

**SECONDARY CARRIER**

Name of Insured \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance carrier name \_\_\_\_\_  
Employer \_\_\_\_\_  
Union or Local # \_\_\_\_\_  
AID or Group # \_\_\_\_\_  
Member # \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Insurance Carrier address \_\_\_\_\_

Name of Insured \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance carrier name \_\_\_\_\_  
Employer \_\_\_\_\_  
Union or Local # \_\_\_\_\_  
AID or Group # \_\_\_\_\_  
Member # \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Insurance Carrier address \_\_\_\_\_

1. Do you have, or have you had any of the following:

- Anemia
- Heart Murmur
- Mitral Valve Prolapse
- High Blood Pressure
- Rheumatic Fever
- Respiratory Disease
- Tuberculosis
- Nervous Disorders
- Diabetes
- Excessive Bleeding

- Hip or Joint Replacement
- Blood Diseases
- Hepatitis, Jaundice, or Liver Disease
- Kidney Disease
- Tumors or Growths
- Radiation Treatment of Any Kind
- Allergies
- Asthma or Hay Fever
- Glaucoma

- Fainting Spells or Seizures
- Sinus Trouble
- Rheumatism or Arthritis
- Head Injuries
- Stomach Ulcers
- Venereal Disease
- Epilepsy
- Stroke

1. Are you in good health?  Yes  No
2. Date of last medical exam \_\_\_\_\_
3. Have you ever been hospitalized?  Yes  No  
If so, what was the problem? \_\_\_\_\_
4. Are you taking any drugs or medication?  Yes  No  
If so, what? \_\_\_\_\_
5. Do you have any disease, problem or condition you think I should know about?  
\_\_\_\_\_

10. Do you smoke?  Yes  No
11. Do you wear a cardiac pacemaker?  Yes  No
12. Have you had heart surgery?  Yes  No
13. Are you now under care of M.D.?  Yes  No
14. Have you had any serious illness?  Yes  No
15. Blood Pressure, if known \_\_\_\_\_
16. Do you have any sensitivity to latex?  Yes  No
17. Do you have a history of chemical dependency?  Yes  No  
(If yes, then the dentist will follow up in confidence.)

6. Do you have any disease or have you had a transplant operation that has depressed your immune system?  Yes  No
7. Have you ever taken Fen-Phen?  Yes  No
8. Had you had an allergic reaction to bananas?  Yes  No
9. Are you sensitive or allergic to any drugs?  Yes  No  
If so, please list \_\_\_\_\_

Physician's name _____		
Address _____	Phone _____	

FOR WOMEN ONLY

Are you taking birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long?	<input type="checkbox"/> 1 - 3 mos.	<input type="checkbox"/> 3 - 6 mos.	<input type="checkbox"/> 6 - 9 mos.
Physician's name _____				
Address _____		Phone ( ) _____		

DENTAL HISTORY

1. How long since your last visit to a dentist? \_\_\_\_\_
2. Reason for this visit? \_\_\_\_\_
3. How often do you floss your teeth? \_\_\_\_\_
4. Have you ever been treated for periodontal disease?  Yes  No
5. Have you ever had any complications from an extraction?  Yes  No  
If yes, explain \_\_\_\_\_
6. Have you ever had a popping or clicking near your ear when you chew?  Yes  No
7. Are you prone to frequent headaches?  Yes  No
8. Do you grind or clench your teeth?  Yes  No
9. Do your gums bleed when you brush?  Yes  No
10. Do you have sores, blisters, or swelling on your gums, lips or cheeks?  Yes  No
11. Have you ever had orthodontic treatment?  Yes  No
12. If you could change something about your smile what would it be? \_\_\_\_\_
13. Do you snore?  Yes  No
14. Do you have problems with bad breath?  Yes  No
15. Have you ever had an allergic reaction to a metal filling, crown or dental appliance?  Yes  No
16. Have you ever used an electronic toothbrush?  Yes  No

Previous Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone ( ) \_\_\_\_\_

REMARKS

IS THERE ANY ADDITIONAL MEDICAL OR DENTAL INFORMATION WE MAY NEED TO KNOW ABOUT BEFORE BEGINNING TREATMENT? \_\_\_\_\_

CONSENT

Minor: I, being the parent (or guardian) of the above named minor patient, do hereby authorize the performance of dental services upon this patient and whatever procedures the judgement of the doctor may dictate in order to carry out treatment procedures as outlined on the treatment plan form. I also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by the doctor.

Adult: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

I understand that my dental care insurance carrier or payor of my dental benefits may allow less than the actual bill of services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I agree to re responsible for payment of services not paid, in whole or in part, by my dental care payor.

I attest to the accuracy of the information on this page.

Relative \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

Signature \_\_\_\_\_



# Uptown Dental Care

## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

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### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, and are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization, via a separate form we can provide or a letter in your own writing, to use your health information or to disclose it to anyone for any purpose. If you give us a special authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a special written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information this is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of other.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may also disclose to correctional institutions or law enforcement official having lawful custody of protected health information if inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$25.00 per patient file for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request communication with you about your health information by alternative means or to alternative locations (request must be made in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information (request must be in writing, and must explain why the information should be amended). We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Website or by electronic mail, you are entitled to receive this Notice in written form.

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**David Silber**  
**Uptown Dental Care**  
**2800 Routh St. Ste. 255**  
**Dallas, TX 75201**

**E-mail: [Doctor@davidsilber.com](mailto:Doctor@davidsilber.com)**  
**Phone: 214-740-1186**  
**Fax: 214-740-9781**

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Date: \_\_\_\_\_

## UPTOWN DENTAL CARE

### **FINANCIAL AGREEMENT**

Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

### **INSURANCE FILING**

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event you insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.

### **ASSIGNMENT OF INSURANCE BENEFITS**

I/we hereby assign directly to Uptown Dental Care, dental insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

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Responsible Party Signature

### **DELINQUENT ACCOUNTS**

All delinquent accounts (30 days or older) are subject to reasonable service charges and/or legal interest rates.

### **COLLECTION PROCEEDINGS**

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for payment of regular fee for procedures at the time of service.

### **FAILED APPOINTMENTS**

Failed appointments (less than 24 hours notice) are a significant contributor to rising health care costs. Individuals who fail to show for a confirmed appointment may be assessed a fee based on the length of the missed appointment.

I have completely read and understand the contents of this agreement. I agree to comply with all policies.

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Responsible Party Signature

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Witness/Title



# **CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

## **SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_

## **SECTION B: TO THE 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 carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign 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 of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it 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:

David Silber  
Uptown Dental Care  
2800 Routh St. Ste. 255  
Dallas, TX 75201

E-mail: [Doctor@davidsilber.com](mailto:Doctor@davidsilber.com)  
Phone: 214-740-1186  
Fax: 214-740-9781

**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.

## **SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of the 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 carry out treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

## **Revocation of Consent**

I revoked my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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*\*You May Refuse to Sign This Acknowledgement\**

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ? Individual refused to sign
- ? Communication barriers prohibited obtaining the acknowledgement
- ? An emergency situation prevented us from obtaining acknowledgement
- ? Other (Please Specify)

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