Van Wart Dental Practice

Dr. Christina Noblett Thomas & Dr. Sherry Van Wart-Noblett

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions we'll be glad to help you.
Please email forms to vanwartdental@gmail.com
Please give your insurance card and driver's license to receptionist.

PERSONAL

Name_____
First **Last** **MI** **(Preferred)**

Birthdate_____/_____/_____ SS#_____-_____-_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Other Immediate Family Members at Van Wart Dental & Their Relationship To You: _____

_____

Cell Phone_____-_____-_____ Work Phone_____-_____-_____ Home Phone_____-_____-_____

Email_____

Pick Appropriate Choice: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Address_____

Address 2_____

City_____ State_____ Zip_____

How did you hear about us?_____

EMERGENCY CONTACT

Emergency Contact: Name _____ Relationship To You: _____

Phone # ____-____-_____ Email _____

INSURANCE POLICY – DENTAL ONLY

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Subscriber Birthday _____/_____/_____ Subscriber Social Security#_____-_____-_____

Employer Name_____ Work Phone _____-_____-_____

Insurance Company _____Phone_____-_____-_____

Insurnace Address_____ City, State_____ Zip Code_____

Member # _____ Group # _____

Please present insurance card & driver's license to receptionist.

Medical History – New Patient

Name: _____ DOB: _____

Name of Medical Doctor: _____

If you've had a joint replacement or heart surgery, please provide the name of your surgeon: _____

Please list any medications you are currently taking:

_____

_____

_____

Are you allergic to any of the following? If so, circle all that apply.

Antibiotics	Ibuprofen	Penicillin/Amoxicillin
Aspirin	Iodine	Sulfa Drugs
Codeine	Latex	

Do you have any of the following medical conditions? If so, circle all that apply.

Asthma	Hepatitis A, B, C or D	Pregnant
Bleeding Problems	High Blood Pressure	Psychiatric Treatment
Cancer	HIV/AIDS	Sinus Trouble
Diabetes	Joint Replacement	Stroke
Heart Murmur	Kidney Disease	Ulcers
Heart Trouble	Liver Disease	Rheumatic Fever

Any other important medical conditions not asked above? _____

_____

Tobacco Use? If so, what kind and how much? _____

_____

Past hospitalizations/surgeries? What year? _____

_____

Reason for today's visit? _____

Dental History

Date of last dental exam: _____ Date of last dental x-rays: _____

Previous dentist's name and location: _____

How often do you brush? _____ /day How often do you floss? _____ /week

Are you having pain at this time? Yes No

Do you feel nervous about your dental treatment? Yes No

Have you ever had an unusual reaction to dental injections? Yes No

Do your gums bleed when you brush or floss? Yes No

Have you ever had periodontal/gum disease? Yes No

Have you ever had head, neck or jaw injuries? Yes No

Have you ever had braces? Yes No

Do you wear a denture(s) or partial denture(s)? Yes No

Do you clench or grind your teeth? Yes No

Do your jaws do any of the following: Click/pop Difficulty opening/closing

Pain Difficulty in chewing

Other concerns: _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist/staff at the next appointment without fail.

Signature: _____ Date: _____

Dental Treatment Consent Form

Patient Name: _____

1. WORK TO BE DONE: I understand than I am having dental treatment done, which can include: Fillings, Bridges, Crowns, Root Canals, and Extractions.
2. DRUGS AND MEDICATIONS: I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reactions. I've made the dentist/staff aware of my antibiotics allergy.
3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures or extending a filling to add surfaces. I give my permission to the dentist to make any/all changes and additions as necessary.
4. REMOVAL OF TEETH: Alternatives to removal have been explained to me (root canal therapy, crown, and periodontal surgery, etc.) and I authorize the dentist to remove the teeth elected to be removed and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parenthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
5. CROWNS AND BRIDGES: I authorize the dentist to perform crown or bridge procedures on the elected teeth. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown/bridge (including shape, fit, size, and color) will before cementation. I understand that if temporary if dislodged for too long or if crown cementation is delayed there can be shifting in the teeth that might cause the crown/bridge to need to be remade.
6. COMPLETE AND PARTIAL DENTURES: I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes to my new denture(s) (including shape, fit, size, placement, and color) will be the "teeth in max" try-in visit. I understand that most dentures require relining approximately 3-12 months after initial placement and/or teeth extraction. The cost for this procedure is not included in the initial denture fee.
7. ENDODONTIC (ROOT CANAL): I realize there is no guarantee that root canal treatment will save my tooth/teeth, and that complications can occur from the treatment, and that might require referral to a specialist. I understand that occasionally additional surgical procedures may be necessary following root canal treatment. I understand that following root canal treatment I will need a crown to protect the tooth unless stated otherwise.
8. PERIODONTAL LOSS (TISSUE & BONE): I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that dentist can not guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my self or my minor children. I have had full opportunity to discuss and ask questions regarding my treatment, and all questions have been answered to my satisfaction.

Signature:_____ Date: _____

Drs. Van Wart

2505 Sunset Blvd.
Houston, TX 77005
Office 713-523-1287 Fax 713-523-8424
vanwartdental@gmail.com

Release Of Records

Patient's Name (Print) _____**DOB**_____

_____**DOB**_____

Relationship To Patients: _____**DOB**_____

_____**DOB**_____

____ **I Request latest X-rays /Panos from your office to be sent to Drs. Van Wart's office ASAP**

Previous Office Name:_____

Previous Address: _____

Previous Phone #: _____

Previous Dentist Name:_____

Previous Office Email:_____

Previous Office Fax #:_____

Signature:_____Date_____

Thank You!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining acknowledgement
- ☐ Other(Please Specify) _____

Notice of Privacy Practices

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect «effective_date», 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 such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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 this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.
Required by Law. We may use or disclose your health information when we are required to do so by law.
Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Nicole Nila	
Phone: 713-523-1287	Fax: 713-523-8424
Address: 2505 Sunset Blvd	
E-mail: vanwartdental@comcast.net	