



ESSENTIAL ENDODONTICS

Office Use Only

ID # _____

As a new patient, please take the time to fill out the information below to the best of your knowledge.
If you are unsure about a question, please let the front desk know.

Name: _____ DOB: _____ SSN: _____

Phone: Primary: _____ Secondary: _____ E-mail: _____

Mailing Address: _____
Street City State Zip

Employer: _____ Occupation: _____ How long? _____

Employer's Address: _____
City State Zip

Dental Insurance Information

Ins. Company Name: _____ Phone: _____

Insured's ID # or SSN: _____ Date of birth: ____/____/____ Group#: _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____

Dental History

Have we seen you before? Yes No

Have you had any dental work done so far this year? Yes No

If yes, please explain: _____

If you have had a root canal before, how was your experience? Good Average Not Good

Please Explain: _____

Are there any special dental considerations that we should be aware of?

Please Explain: _____

Family Physician Information

Name: _____

Phone: _____ Last checkup: _____

Allergies

Please circle Y for yes or N for no

General Dentist Information

Name: _____

Phone: _____ Last checkup: _____

Y N Penicillin	Y N Nitrous
Y N Antibiotics	Y N Food: _____
Y N Aspirin	Y N Bleach
Y N Tylenol	Y N Iodine/Seafood
Y N Codeine	Y N Nitrile
Y N Narcotics	Y N EDTA
Y N Local Anesthetic	Y N Ethanol
Y N Latex	Y N Gutta-percha
Y N Ibuprofen	Y N Valium/Tranquil.
Y N Sulfa/Sulfides	Other: _____

Emergency Contacts

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Medical History

Do you or have you had any of the following?

Please circle Y for yes or N for no

Y N Current Medical Treatment	Y N Hypoglycemia	Y N Epilepsy/Fainting	Y N Pacemaker
Y N Prev. Endocarditis (heart)	Y N Tobacco Use	Last episode: _____	When placed: _____
Y N High Blood Pressure	Y N Shortness of Breath	Y N Mental/Neural	Y N Irregular Heart Beat
Y N Respiratory/Asthma	Y N Cancer	Y N Tumor/Neoplasms	Y N Stroke
Last asthma attack: _____	Type: _____	Y N Alcoholism/Addiction	When: _____
Y N Rheumatic Fever	Y N Tuberculosis	Y N Infectious Diseases	Y N Prosthetic Implant
Y N Heart Attack	Y N Fatigue	Type: _____	Y N Any Transplant
When: _____	Y N Swelling	Y N Venereal Diseases	Type: _____
Y N Immunocompromised	Y N HIV/AIDS	Y N Psychiatric Care	Y N Joint Replacement
Y N Anemia/Bleeding	Y N Hepatitis	For: _____	Y N Arthritis
Y N Diabetes/Kidney	Y N Ulcers/Digestive	Y N TMJ	Y N Sleep Apnea
Y N Herpes	Y N Migraine/Headache	Y N Heart Disease	Other _____
Y N Thyroid/Hormonal	Y N Glaucoma/Visual	Y N Heart Murmur/Defect	_____

For Women:

Date of last menstrual cycle: _____

Are you nursing? No Yes

Is there any chance that you may be pregnant? No Yes

Are you pregnant? No Yes/How far along? _____

On birth control? No Yes

Surgical History

If you have had any surgeries, please list what they were and the date below:

Type _____		Date _____
Type _____		Date _____
Type _____		Date _____
Type _____		Date _____

Were there any complications from the surgery? Explain.

Any other conditions you would like us to be aware of:

Medications

Please list all medications you are currently taking and what condition it is for. Please use the back of this page if needed.

Name of Prescription	Condition

Are you currently or have you ever taken bisphosphonates (To treat osteoporosis and some forms of cancer)? (Circle one) Yes No

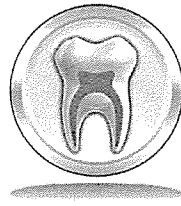
I have read and answered the above questions to the best of my knowledge and understand the importance of a truthful health history to assist the doctor in providing the best care possible.

Patient Signed: _____

Date: _____

Doctor Signed: _____

Date: _____



ESSENTIAL ENDODONTICS

We accept Cash, Check, All Major Credit Cards and Care Credit.

FINANCIAL AGREEMENT

1. I, _____, understand that my insurance coverage is an agreement between myself or the primary policy holder and the insurance company.
2. Essential Endodontics, P.A., Dr. Chris Yelton, D.D.S./Dr. Brett Hill, D.D.S. are third parties to this agreement. Essential Endodontics, P.A. may accept coassignment of my benefits where applicable.
3. The amount of insurance coverage **estimated** for treatment at Essential Endodontics, P.A., is based on information I have provided and other information obtained directly from the insurance company, which may result to be inaccurate in part or entirely.
4. By signing this agreement, I represent that I will be financially responsible for any and all portions of my balance not received from my insurance company.
5. I agree to **pay my portion of today's treatment fees in full**, unless a payment plan has been agreed upon.
6. I agree that if I become **delinquent in a payment plan** established with Essential Endodontics, P.A. that I will be billed for the entire remaining balance and will be expected to pay in full immediately.
7. I agree to pay a finance charge of 2% per month for any balance not received in full within 60 days of this signed agreement. The full APR is 24%. This is effective as of February 1, 2010.
8. I agree to pay a **\$35 charge** for any checks returned from my bank for any reason.
9. I agree to **pay all of the diagnostic charges** today (normally \$165) if I do not accept treatment for today. We will process your insurance, and they will send you a check directly to reimburse you for the covered portion of your visit.
10. I understand that if I do not contact the office ahead of missing an appointment (i.e., 24 hours advance notice unless it's an emergency), I will be responsible for a **\$100 missed appointment charge**.
11. I understand that if my account remains unresolved after 60 days that Essential Endodontics, P.A., Dr. Chris Yelton, D.D. S./ Dr. Brett Hill, D.D.S. will send me to **small claims court**. I will then be responsible for all court fees that Essential Endodontics, P.A. will incur.
12. I understand that a **collections agency** may also be used instead of small claims court. This is dependent on the amount due to Essential Endodontics, P.A.

NOTE TO THOSE NEEDING A PAYMENT PLAN:

We **require** either post dated checks or debit/credit card information for creating a payment plan. This allows us to automatically debit an agreed upon amount at an agreed upon time. If your card is declined, we will run the card everyday for any amount, up to the agreed amount. More details regarding the payment plan will be found on your payment/treatment plan sheet. Finance charges do apply. Please see line 8 for details.

Any bank charges associated with stop payments, insufficient funds, etc., will be added to your account.

Signature of Patient or Responsible Party

Date

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS VIA:

- Cell Phone
- Home Phone
- Work Phone
- Text Message to my Cell Phone
- Email

I AUTHORIZE INFORMATION ABOUT MY DENTAL HEALTH TO BE CONVEYED VIA:

- Message on Cell Phone
- Message on Home Phone
- Message on Work Phone
- Text Message
- Email
- In-Person
- Any of the above

(Initial one)

_____ I agree that the dental practice may communicate with me electronically at the email address I provide and I am responsible for providing the dental practice any updates to my email address.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

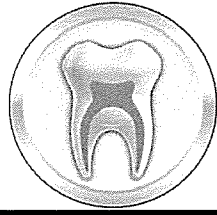
_____ I do NOT give consent for the dental practice to communicate with me electronically.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or guardian's) signature on this Acknowledgement but did not because:

- It was an emergency treatment
- I could not communicate with the patient
- The patient refused to sign
- Other (Please describe): _____

Signature of Privacy Officer Only



ESSENTIAL
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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.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Jim Moore - 469.342.8300, Extension 508

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by Federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for procedures may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and staff training.

For example, we may disclose your protected health information to interns or preceptors that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses. We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "Business Associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a Business Associate involves the use or disclosure of your protected health information, we will have a written agreement with that Business Associate that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable Federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please ask your doctor if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

You may request a restriction by presenting your request, in writing to a staff member in our office. The staff member will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff member provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your doctor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please ask your doctor if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limits.

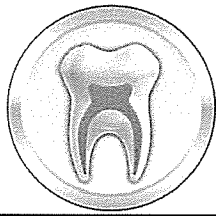
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, to the Texas Attorney General's Office, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Jim Moore, a Certified HIPAA Professional. You may contact our Privacy Officer in writing at our office address or by calling 469.342.8300, Extension 508. Our website may offer additional information about the complaint process.

This notice was published and becomes effective on March 15, 2017.



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Acknowledgement of Receipt Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

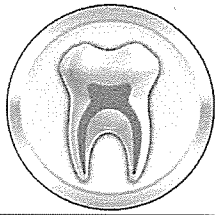
Time

Print Patient's Full Name

Witness Signature

Date

Time



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**Patient Authorization
Release of Protected Health Information Records**

Information to Be Released

Information covered by this authorization includes: _____

Release of Records

The information listed above will be released to:

Name of person, organization and address or fax number to which records should be sent - Please double-check fax number for accuracy

Purpose of this Release

For treatment at the facility to which records are sent Other reason _____

The Protected Health Information specified in this Release will be used solely for the purposes of treatment, payment and healthcare operations. Our facility complies with all applicable Federal and State privacy laws.

By my signature below I give permission to release the specified information.

Patient or Legally Authorized Individual Signature

Date

Time

Print Patient's Full Name _____

Witness Signature

Date

Time