PATIENT REGISTRATION

Patient Information:

(Please Print)

First Name: ______________________________ **Last Name**: ______________________________________

Address: _________________________________ **City, State, Zip Code**: ______________________________

Home Phone: _____________________________ **Work Phone**: _____________________________________

Cell Phone: _______________________________ **Referred By**: _____________________________________

Email: ___________________________________ ***I would like to receive email correspondence***: Yes / No

Social Security No: _________________________ **D.O.B.**_______________**DL#**:________________________

Emergency Contact: ____________________________ **Phone**: ______________________________________

Sex: Male / Female **Marital Status**: single married divorce separated widow

Primary Insurance Information:

Name of Insured: ____________________________ **Relationship to Patient**__________________________

Insured Birthdate:____________________________ **Insured Social Security No.**______________________

Insured's Employer: __________________________ **Employer Phone**: _______________________________

Insurance Company: __________________________ **Insurance Phone**:_______________________________

Insurance Identification Number: ________________ **Insurance Group No.**__________________________

✦Do you have any additional insurance? □Yes □No If yes, Complete the following:

Name of Insured: ____________________________ **Relationship to Patient**: _________________________

Insured Birthdate:____________________________ **Insured Social Security No.**______________________

Insured's Employer: __________________________ **Employer Phone**: _______________________________

Insurance Company: __________________________ **Insurance Phone**: ______________________________

Insurance Identification Number: ________________ **Insurance Group No.**__________________________

X____

_Signature of Patient or Parent/Guardian if Minor

Patient Medical/ Dental History

Are you under medical treatment now? □Yes □No If yes, please explain___________________

Have you ever been hospitalized or had a major operation? □Yes □No if yes, please explain ___________________

Are you taking any medications, pills or drugs? □Yes □No If yes, please explain ___________________

Have you ever taken Fen-Phen/Redux? □Yes □No Are you wearing contact lenses? □Yes □No Do you use tobacco? □Yes □No

Do you use alcohol, cocaine or other drugs? □Yes □No

Have you had any orthodontic work? □Yes □No

Do you clench or grind your teeth? □Yes □No

Are you teeth sensitive to hot or cold? □Yes □No

Do your gums bleed while brushing or flossing? □Yes □No

Do you feel pain to any of your teeth? □Yes □No

Do you bite you lips or cheeks frequently? □Yes □No

Do you have any sores or lumps in or near your mouth? □Yes □No

Have you ever had prolonged bleeding following extractions? □Yes □No Are your teeth sensitive to sweet or sour liquids/foods? □Yes □No

Have you ever experienced any of the following problems in your mouth? Difficulty in opening or closing/ Clicking/ Pain (joint, Ear, Side of Face)

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? □Yes □No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs Barbiturates Sedatives Iodine

other___________________

Do you have or have you had any of the following?

AIDS/HIV Positive
Alzheimer's disease
Allergies
Anemia
Angina
Arthritis/Gout
Artificial Heart valve
Artificial Joint
Asthma
Breathing Problem
Bruise Easily
Cancer
Chemotherapy

Easily Winded
Emphysema
Fainting Spills/Dizziness
Frequent Headache
Genital Herpes
Glaucoma
Hay fever
Heart Attack/ Failure
Heart Murmur
Heart Pace Maker
Heart Trouble/Disease
Hemophilia
Venereal Disease

Diabetes
Chest Pains
Hepatitis A B or C
Joint Replacement
Herpes
High Blood Pressure
Irregular Heart
Jaundice
Low Blood Pressure
Liver Disease
Leukemia
Kidney Problems

Drug Addition
Cold Sores/ Fever Blisters
Convulsions
Rheumatic Fever
Sexual Transmitted Disease
Sinus Trouble
Shingles
Stroke
Swollen Ankles
Thyroid Problems
Tuberculosis
Ulcers
Yellow Jaundice

Women only:

Are you pregnant or think you may be pregnant? □Yes □No Are you nursing? □Yes □No Are you taking birth control pills? □Yes □No

X___________________

Signature of Patient or Parent/Guardian if Minor (I certify that I have read and understand the above information)

Morgan & Associates Dental Office

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

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 (04/14/03), 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. 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 to 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 this Notice.

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 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 quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, 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 to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by

your authorization while in effect. Unless you give us 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 must 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 your healthcare or with payment for 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 health information, we will provide with an opportunity to object to such uses or disclosures. In event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that 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 inferences 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 making communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so 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, neglect, 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 others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of 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).

Patient Rights

Access: You have the right to look at 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 a minimum of $50 ($1for each page, $25 per hour for staff time to locate and copy your health information) duplication of x-rays, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or

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 year, 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 so, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must be 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. (Your request must be in writing, and it 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

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

If you are concerned that we may have violated your privacy rights, or 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 the Notice.

You also may submit a written complaint with 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 your 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.

Contact Office: Ursula at Morgan & Associates Dental Office

Telephone: (713) 668-4800 **Fax:** (713) 668-5004

Address: 9231 Stella link Rd., Houston, TX 770025

customersvc@morganandassociatesdental.com

Phyllis J. Morgan, D.D.S.

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 obtain 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 acknowledgment
- □ An emergency situation prevented is from obtaining acknowledgement
- □ Other (Please Specify)

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Practice Policy

Thank you for choosing Morgan & Associates Dental Office, "We are determined to make you smile." In effort to better serve you, we would like to take the time to explain the billing process at our office.

- **Insurance:**

Morgan & Associates Dental Office will file claims directly with your insurance carrier as a courtesy to you, once you provide us with your dental insurance. Your insurance policy is a contract between you, your employer, and the insurance company, and we are ***not*** a party to that contract. We will be happy to assist you in estimating your portion of the cost of treatment, but at no time should our assistance be construed as a "guarantee of payment". The information we receive from your insurance company is only an estimate of coverage and **not** a guarantee of payment. We allow 30 days from the date a claim was filed by our office for insurance company to pay. If your insurance company has not paid within this time, you will receive a statement in the mail and you are responsible for the entire balance of your account without further notice.

- **Method of Payment:**

For your convenience, Morgan & Associates Dental Office will be happy to accept your personal check, cash, Visa, MasterCard, Discover, American Express and Flex Card as payment for your dental services. •Please note, there will be a fee for all returned checks.

  - **Minors:**

  The parent/guardian of a minor are responsible for payment for services provided. Unaccompanied minors must have a written authorization for dental treatment signed by parent or guardian, and a payment arrangement before services can be provided.

Our goal is to provide quality dental care in a timely manner. In order to do so we have implanted a cancellation policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

- **Appointment:**

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. We ask you make an attempt to call at least 24 hours in advance.

- **Late Arrivals:**

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late too your scheduled appointment, you may be asked to reschedule.

I have read and understand the "Practice Policies".********

Print Name____________________________________ Date Signed________________________

X Signature____