BelieveDental

New Patient Information

Welcome to Believe Dental! We are so glad you are here! To help us better serve you or your loved one, please fill out the following questions. Any health conditions or medications could help determine the dental services you will receive.

Patient Full Name _____ Date of Birth _____

Preferred Name _____ Home Phone _____ Work Phone _____

Home Address (Street / City / Zip) _____

Parent/Guardian Full Name _____ Date of Birth _____

Email _____ Driver's License # _____ SSN _____

Employer Name & Address _____

How did you hear about Believe Dental? _____

If the patient has any disabilities, please describe, including behavioral challenges (e.g., self-harm, stimulating, yelling), and any effective rewards for good behavior (toys, music, movies, books, stickers, stuffed animals, videogames, etc.):

_____

_____

_____

Please describe the patient's diet, including any favorite foods: _____

_____

Does the patient have any physical challenges (e.g., low vision, wheelchair, low muscle tone, fine motor skills, etc.)?

_____

_____

Has the patient visited the dentist before? **Y / N** How long ago was the most recent visit? _____

What was the most recent experience like? _____

_____

Please describe your / the patient's at-home oral care:

Brushing frequency _____ Aided or independent _____ Type of toothbrush _____

Type of toothpaste _____ Flossing frequency _____ Aided or independent _____

Mouthwash frequency _____ Any issues spitting _____ Flouride/varnish OK? _____

Who helps the home care routine _____ Any challenges brushing /flossing at home _____

Where/in what position do you brush your teeth _____

Information to help our staff provide the best experience possible for the patient:

Is the patient able to communicate verbally, and if so at what age level? _____

Any verbal cues that might help our team, e.g., "hands quiet, mouth quiet"? _____

Do you use non-verbal communication (PECS, AAC, ASL, etc.)? _____

Sensitivity to any sounds / sights / flavors? _____

Any oral-specific issues, e.g., pica (eating non-food objects), pouching, thumb sucking, etc.? _____

Does the patient currently see any therapists (e.g., **OT / PT / Speech / ABA**)? Circle any that apply.

If so, where and for how many hours a week? _____

_____

If the patient has difficulty with today's dental visit, would you like to work with a Board-Certified Behavior Analyst for a "practice" dental visit? _____

Sex:

Y	N	PLEASE ANSWER THE FOLLOWING:
		Do you smoke or use tobacco?
		WOMEN:
		Are you taking birth control pills?
		Are you pregnant?
		Are you nursing?

If pregnant, how many weeks? _____
Height _____ Weight _____

Y	N	ALLERGIES:
		Aspirin
		Codeine
		Dental Anesthetics
		Erythromycin
		Jewelry
		Latex
		Metals
		Penicillin
		Tetracycline
		Other:

Y	N	Condition:	Y	N	Condition:
		Abnormal Bleeding			Heart Surgery
		Alcohol Abuse			Hemophilia
		Allergies			Hepatitis A
		Anemia			Hepatitis B
		Angina Pectoris			High Blood Pressure
		Arthritis			HIV+ AIDS
		Artificial Heart Valve			Kidney Problems
		Artificial Joints (Knee, Hip, etc.)			Liver Disease
		Asthma			Low Blood Pressure
		Blood transfusion			Mitral Valve Prolapse
		Cancer-Chemotherapy			Pace maker
		Colitis			Pneumocystis
		Congenital Heart Defect			Psychiatric Problems
		Cosmetic Surgery			Radiation Therapy
		Diabetes			Rheumatic Fever
		Difficulty Breathing			Seizures
		Drug Abuse			Shingles
		Emphysema			Sickle Cell Disease
		Epilepsy			Sinus Problems
		Fainting Spells			Stroke
		Fever Blisters			Thyroid Problems
		Frequent Headaches			Tuberculosis
		Glaucoma			Ulcers
		Hay Fever			Venereal Disease
		Heart Attack			Yellow Jaundice
Any other condition not listed:					

Have you had any major surgeries? _____

_____

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Medications:

Primary Insurance Information:

Subscriber Name & Address _____

Relation to Patient _____ ID# _____ DOB _____

Insurance Company Name & Address _____

_____

Insurance Phone # _____ Group # _____ Member ID _____

Secondary Insurance Information:

Subscriber Name & Address _____

Relation to Patient _____ ID# _____ DOB _____

Insurance Company Name & Address _____

_____

Insurance Phone # _____ Group # _____ Member ID _____

Responsible Party for Patient: _____

Signature: _____

Do you have any expectations you'd like to share with us about your visit? Any fears or concerns? Any additional information you feel our staff should know to provide the best care possible:

Consent: The undersigned hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs, including but not limited to x-rays, study models, photographs, medications, and the use of local anesthetic agents. If Believe Dental in any way participates in scheduling transportation services, I, on behalf of myself, the patient, and our respective representatives, affiliates, agents, and heirs, voluntarily release, waive, discharge, hold harmless, defend and indemnify Believe Dental and its affiliates, owners, agents, officers, and employees from and against any and all claims, actions, or losses for bodily injury, property damage, death, or otherwise, which may arise from said transportation services.

Signature _____ Date _____

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Notice of Billing Policies and Use of Insurance

As a courtesy, our office makes every effort to work with your insurance company on your behalf. However, payment to our office for services rendered is your responsibility. You will receive a statement every month until your insurance has paid and your account is at a zero balance. It is always helpful for you to call and check with your insurance company regarding the status of your claim.

If you are using insurance, the payment amount we collect today is only an estimate based on your insurance provider's payment guidelines. If your insurance provider does not pay what was originally expected, you will be responsible for the remaining balance. If your insurance provider pays more than the originally expected amount, we will send a refund check to your listed address.

For patients with Medicaid benefits:

I understand that, in the opinion of Believe Dental, the services (or items) that I have requested may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for the patient's care. I understand that the HHSC or its health insuring agent (e.g., DentaQuest, MCNA, or UHC) determines the medical necessity of such services. I also understand that I am responsible for payment of the services I (or the patient) request and receive if these services are determined not to be reasonable and medically necessary. If services are so determined, I understand that Believe Dental is accepting me (or the patient) as a private pay patient for the purposes of providing those services, and I will be responsible for paying for those services. The provider will not file a claim to Medicaid for those services that I pay for.

I accept these conditions:

_____ _____

Patient or Guardian Signature Date

I do not accept these conditions and will pay in full at the time of service:

_____ _____

Patient or Guardian Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (patient or guardian), have received a copy of Believe Dental's Notice of Privacy Practices.

_____ _____
Patient or Guardian Signature Date

Staff will fill out this section if patient's or patient guardian's signature not obtained:

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

___ Patient refused to sign.
___ Emergency situation prevented us from obtaining the patient's signature.
___ Language barriers prevented us from obtaining the patient's signature.
___ Other (explain): _____

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 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 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 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 to request a copy of our Notice, please contact us using the information listed on this website.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and 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 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 using your health information for treatment, payment or operations, you may give us written authorization to use your information or to disclose it to anyone for any purpose. If you give us 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 written authorization, we cannot use or disclose your health information for any reason except as 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 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 or 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 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 marketing 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, 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 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 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 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.

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, 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 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 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 website 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 concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, 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 on this website. 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.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

Privacy Officer: Karan Shah, DMD

Email: info@believedental.com

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Believe Dental Media Release Form

I hereby authorize Believe Dental ("BD" or the "Company") to publish images, names, photographs, videos, testimonials, and/or other materials (the "Content") of myself, my child(ren) and/or legal dependent(s). I understand that the Content may be used on the Company's social media pages or other marketing materials.

I acknowledge that my/our participation is voluntary and that I will not receive compensation or consideration of any kind in exchange for the creation, publication, or dissemination of the Content. I acknowledge and agree I will maintain no right of ownership.

I hereby release BD, its owners, employees, contractors, affiliated partners, and any third parties involved in the creation or publication of the Content, from any liability or claim by me or any other person, in connection with my/our participation in the creation, publication, or dissemination of the Content.

A parent or legal guardian over the age of 18 must sign this form.

Authorization

Patient name _____

Print name _____

Signature _____

Date _____

Street Address _____

City _____ State _____ Zip _____

Phone number _____ Email Address _____