Welcome

Patient Information (CONFIDENTIAL)

Name _____ Birth date _____ Date _____
Address _____ City _____ State _____ Zip _____
Marital Status: Minor Single Married Divorced Widowed Sex: M F Home Phone _____
Occupation _____ Employer _____ Work Phone _____
Soc. Sec. # ___ - ___ - ___ Pager _____ Cell Phone _____
Spouse or Parent's Name _____ Employer _____
Emergency Contact _____ Phone _____
Referred by _____

Responsible Party

Name _____ Relationship _____
Address _____ Home Phone _____
Soc. Sec. # ___ - ___ - ___ Employer _____ Work Phone _____
Birth date _____ Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship _____
Birth date _____ Soc. Sec. # ___ - ___ - ___ Date Employed _____
Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Deductible $ _____ Max. Annual Benefit _____
Do you have other dental insurance? ☐ Yes ☐ No If Yes, Name: _____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?	Y	N
2. Have you ever been hospitalized?	Y	N
3. Are you taking any medications?	Y	N
If yes, what medication(s) are you taking?		
4. Do you use tobacco?	Y	N
5. Do you use alcohol, cocaine or other drugs?	Y	N
6. Are you wearing contact lenses?	Y	N

7. Are you allergic to or have you had any reactions to the following?

Local Anesthetics	Y	N
Penicillin or other Antibiotics	Y	N
Sulfa Drugs	Y	N
Barbiturates	Y	N
Sedatives	Y	N
Iodine	Y	N
Aspirin	Y	N
Other	Y	N

8. Women only:

Are you pregnant?	Y	N
Are you nursing?	Y	N
Are you taking birth control pills?	Y	N

9. Please circle if you have now or have had any of the following:

High Blood Pressure	Heart Disease	Chest Pains
Heart Attack	Cardiac Pacemaker	Easily Winded
Rheumatic Fever	Heart Murmur	Stroke
Swollen Ankles	Angina	Hay Fever / Allergies
Fainting / Seizures	Frequently Tired	Tuberculosis
Asthma	Anemia	Radiation Therapy
Low Blood Pressure	Emphysema	Glaucoma
Epilepsy / Convulsions	Cancer	Recent Weight Loss
Leukemia	Arthritis	Liver Disease
Diabetes	Joint replacement or Implant	Heart Trouble
Kidney Disease	Hepatitis / Jaundice	Respiratory Problems
AIDS or HIV Infection	Sexually Transmitted Disease	Thyroid Problems
Stomach Problems / Ulcers	Psychiatric Treatment	Other

Patient Dental History

Frequency of Care: 3 mos. 6 mos. 1-2 yrs. 2-5 yrs. 5+ yrs.

Date of last cleaning appt._____Were dental X-rays taken? Y N

Reason for this dental visit?_____

1. Do your gums bleed while brushing or flossing? Y N
2. Are your teeth sensitive to: Hot? Cold? Sweets? Pressure? Y N
3. Do you feel pain in any of your teeth? Y N
4. Do you have any sores or lumps in or near your mouth? Y N
5. Have you had any head, neck, or jaw injuries? Y N
6. Do you have frequent headaches? Y N
7. Do you clench or grind your teeth? Y N
8. Have you ever had any difficult extractions in the past? Y N
9. Have you had any orthodontic work? Y N
10. Have you lost any teeth or have any teeth been removed? Y N
11. Have they been replaced? Y N Fixed Bridge? Removable appliance? Denture?

Dental Home Care Products Used:

12. Toothbrush: Hard Medium Soft Electric
13. Toothpaste: Regular Desensitizing Tartar Control Whiteners Baking Soda
14. Floss: Waxed Unwaxed

15. Do you have any questions or concerns?_____

_____

Patient Signature_____**Date**_____

SCOTT STEIN, DDS

We feel it is important to outline our financial policies in order to help you understand the methods of payment in our office. Please read the following and don't hesitate to ask any questions you might have regarding these financial policies.

- **Full payment is expected at the time service is rendered. This includes any copayments and/or deductibles if you are using insurance.**
- Payments are accepted in the form of CASH, MASTERCRD, VISA,DISCOVER AND AMERICAN EXPRESS CARDS, CHECK AND CARE CREDIT.
- A 3% discount will be given if your treatment plan is over $750.00 and charged on a credit card in full (This discount applies to cases without insurance plans involved.)
- A 5% discount will be given if your treatment plan is over $750.00 and CASH OR CHECK is given for payment. (This discount applies to cases without insurance plans.)

INSURANCE POLICIES

As a courtesy to our patients with dental insurance, our office will file the insurance claim on the treatment rendered. We will assist you with the filing of your claims provided you provide us with complete and current insurance information. However, if your insurance carrier has not paid within 45 days of treatment, you will become responsible for the outstanding balance. Since your policy is a contract between your employer and insurance carrier, you may be responsible to take up the matter with the insurance company directly if any treatment is denied.

Any non-payment by the insurance company will become your responsibility and payment will be expected in full from the patient.

Regardless of the insurance company's determination of usual & customary fees or amount of assignment, you are also responsible for any fees not covered. Statements will be sent at the end of each month and differences will be expected in full.

Any procedure recommended and performed in this office that is not covered by insurance will be the patients full responsibility.

I have read the financial policies and have had my questions answered to my satisfaction regarding these policies. By signing this statement, I agree to the terms outlined above.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Dr Scott Stein DDS

General Consent Form for Treatment

Patient's Name:_____ Birthdate:_____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the office of Dr. Scott Stein DDS. These procedure include, but are not limited to; exams, x-rays, oral prophys(cleanings), fluoride treatments, sealants, restorations(all fillings-silver and composites and crowns), periodontal treatments, root canals, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____ _____ _____

(print your name) (relationship to patient) (date)

Your Signature: _____

Consentimiento para Tratamiento Dental

Nombre del Paciente:_____ Fecha de nacimiento:_____

Doy el consentimiento para mi o mi nino/nina para recibir el tratamiento dental que sea necesario, por los proveedores en el consultorio de Dr. Scott Stein DDS. Estos procedimientos incluyen, pero no estan limitados a: examenes, radiografias, limpiezas, fluoruro, selladores, restauraciones, coronas, tratamiento de periodoncia, endodoncias, extracciones, y el uso de anestesicos locales. Entiendo que el uso de anestesicos locales conlleva el possible riesgo de hinchazon, hematomas, cambios en la percecion de dolor o adrmecimiento prolongado.

Este consentimiento se considerara vigente a menos que sea revocado.
Su nombre:_____ Relacion:_____

Fecha de Hoy:_____ Su Firma:_____

Dr. Scott Stein
(Name Of Practice)

Acknowledgement Of Receipt Of Notice Of Privacy Practices

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

Print Name

Signature

For Our Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

_____ Patient refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Describe below)

Dr. Scott Stein
[Insert Name of Practice]

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. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an **Acknowledgement Of Receipt Of Notice Of Privacy Practices.** Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by 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 pay your health care bills and to support the operation of the our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room 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.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory 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 contract 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 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 may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon 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. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

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

We may use and disclose your protected health information in the following instances. 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 we 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.

Family and Friends: 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 to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent

Required By Law: We may use or disclose your protected health information when we are required to do so by law.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement Of Receipt Of Notice Of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, 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 health care. .

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 heath or safety or the health and safety of others.

Military Activity and 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 institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances..

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.

Your Rights

You have the right to inspect and copy your protected health information. 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 practically do so. You must make the 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 prefer, we will prepare a summary or an explanation of your health information for a fee.

You have the right to request a restriction of your protected health information. 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.

You have the right to request alternative communications from us. 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.

You have the right to request an amendment your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. 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.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you make file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health And Human Services.

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.

Effective Date. _____

Privacy Officer: Scott Stein Telephone: _____

Fax: _____ Email: _____

Address: _____

Dr. Scott Stein
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El Paso TX 79912-1748