Dental Care Association
General, Cosmetic & Orthodontic Dentistry

Welcome!

We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to enable you to have a beautiful smile that lasts a lifetime. Please visit us at www.DentalCareAssociation.com

Today's Date ______________

Patient Information

First Name ____________________ MI ______

Last Name ______________________________

Birth Date ________ Age _____ SS# __________

☐ Married ☐ Single ☐ Divorced ☐ Domestic Partnership
☐ Separated ☐ Widowed

Address ______________________________

City: ____________________ Zip: ______

Home# ____________ Cell# ____________

Employer ____________ Work# ____________

Occupation ______________________________

Email ______________________________

Referred by ______________________________

Emergency Contact Name ____________________

Emergency Contact Phone # ____________________

Responsible Party

First Name ____________________ MI ______

Last Name ______________________________

BirthDate ________ Age _____ SS# __________

Employer ____________ Work# ____________

Occupation ______________________________

Employer's Address ____________________

____

Primary Dental Insurance

Insurance Co. Name ____________________

Insurance Co. Address ____________________

Insurance Co. Phone # ____________________

Plan ______ Group ________ Policy __________

Policy Owner's name ____________________

Relationship to patient ____________________

Policy Owner's BirthDate ________ SS# __________

Policy Owner's Employer ____________________

Employer's address ____________________

____

Do you have another dental insurance? Yes No

Dental History

Purpose of Today's Visit ____________________

Previous Dentist ____________________

Date of your last Visit ____________________

What was done? ____________________

Last Cleaning __________ Gums Bleed __________

How often do you brush? ____________________

Any ☐ Sensitive Teeth ☐ Loose Teeth ☐ Broken fillings
☐ Jaw Pain ☐ Injuries to Teeth

Explain ______________________________

Do you like your smile?	Y	N
Do you feel nervous about having dental treatment?	Y	N
Do you want straighter teeth?	Y	N
Are you interested in whitening your teeth?	Y	N
Are there old fillings or dental work that you would like to change?	Y	N
Do you Snore?	Y	N
Do you have tired jaws, especially in the mornings?	Y	N
Do you wear removable dentures or partial dentures?	Y	N
Are you using any other dental devices (i.e. retainer, bite guard, snoring appliance)?	Y	N
Do you have an unpleasant taste or bad breath?	Y	N
Do you think your dental health affects your overall physical health?	Y	N
Have you ever been told you have Periodontal disease?	Y	N

If you could change anything about your smile, what would it be?

____

Do you?

__ Smoke Packs per day? ______ How long? ________

__ Chew Tobacco

__ Drink Per week? ______ Per month? ________

__ Wear Contact Lenses

__ Take Diet Pills

__ Take Recreational Drugs

Permission for Treatment by Dental Care Association

I, ________________________________, request examination and/or treatment for myself, or my child by the personnel of Dental Care Association (DCA). The need for the examination, dental radiographs, intra-oral photos, treatment and the possibility of undesirable side effects will be explained to me by employees of DCA. I understand there is no guarantee or assurance concerning the results which may be obtained, however, normal prudent care will be exercised by employees of DCA in my diagnosis and treatment.

I authorize Dental Care Association to release medical/dental information to my insurance carrier(s) for the purpose of paying for any services rendered to me, and to release information to another dentists, physicians, or hospitals to whom I may be referred.

By signing below I certify that I understand the nature of the Permission for Treatment, and allow Dental Care Association to perform preliminary treatment needed to improve and/or maintain my oral health.

Patient/Guardian Name: __________________________ Patient/Guardian Signature: __________________________

Dental Care Association's Office Policies

Dental Care Association is very pleased to participate in your dental healthcare. As a courtesy to our patients, we will complete and file insurance claims on your behalf. It is important to understand that most insurance companies do NOT guarantee payment to healthcare providers until the claim is received. We will give you an estimated cost of your necessary treatment, which will also include an estimate of your dental benefits. However, any fees not paid by your insurance company will be the patient/guardian's responsibility to pay to Dental Care Association (DCA). DCA will allow 30 days for payment from your dental insurance carrier. If payment(s) is not received, patient/guardian will pay outstanding insurance balance to DCA. Once monies have been received by your insurance carrier they will automatically be sent to patient/guardian as reimbursement. We encourage you to understand your insurance coverage and refer to your member handbook or call your plan administrator with any questions or concerns relating to specific benefits. **Initials: ________**

The Team at Dental Care Association takes great pride in assuring wonderful customer service to all of our patients. Being able to maintain great customer service to all, we encourage everyone to arrive on time for their reserved appointments with our office. This will assure that your healthcare provider has enough time to complete your needed treatment and to the other patients who follow. If you will be late for your appointment, a courtesy call to our office would be appreciated. If you are more than 15 minutes late for your reserved appointment, we may not be able to see you that same day.

- **If you need to change your appointment date/time, we require 24-48 hour notice in advance. If appointment is cancelled on same day or patient no shows to their appointment, your account will incur a $25 fee.**
- **Patients with 3 no shows within a 12 month period will be subject to discharge from our practice.**

Initials: ________

Treatment plans are given to all patients who are in need of treatment. Payment is expected for all services rendered by Dental Care Association. We offer financing by several third party companies, as a courtesy for all of our patients who wish to apply. Further information can be given by office personnel.

By signing below I certify that I understand and will abide to the office policies for Dental Care Association.

Patient/Guardian Name(Print): ___________________________________ Today's Date: ___________________

Patient/Guardian Signature: ____________________________________

Dental Care Association

Information on Patient Rights under HIPAA
Notice of Privacy Practices

This information is to help you understand your rights under privacy regulations, the Health Insurance Portability and Accountability Act, or HIPAA. This page focuses on your right to receive a Notice of Privacy Practices (Notice).

What is a Notice of Privacy Practices?

The Notice of Privacy Practices, or Notice, describes the Health Science Center's privacy practices. It describes how we use or disclose your medical or health information. It also explains your rights as a patient under privacy regulations, as well as the Health Science Center's responsibilities regarding your information.

Why do I need a Notice of Privacy Practices?

We are required by federal regulations to maintain the privacy of your medical or health information. We create a record of the care and services you receive at the Health Science Center. We need this record to provide you with quality care and to comply with certain legal requirements. The Notice will help you understand how to exercise your rights regarding your health information.

How do I get a copy of the Notice?

At your first visit to the Health Science Center, staff should provide you the opportunity to review and request a copy of the Notice. Or, you may call the Health Science Center, and we will send you a copy in the mail. You may also download a copy from our website at www.uthscsa.edu/hipaa under the Patient Rights section.

How do I get more information about certain rights discussed on the Notice?

For additional information on your rights from the list below, you may:

1. Ask Health Science Center staff for forms or written information when available.
2. To access information from the website at www.uthscsa.edu/hipaa under the section titled "Patient Rights under HIPAA" by clicking on the topic in which you are interested:
    - Right to access. (Information on how to inspect and obtain a copy of your health information.)
    - Right to accounting of disclosures. (Information on how to request an accounting of disclosures made on your health information.)
    - Right to amendment. (Information on how to request an amendment to your health information.)
    - Right to request confidential communications. (Information on how to request that we communicate with you about your health information at alternative locations.)
    - Right to complain for privacy rights violations. (Information on your right to complain if you feel that we have used or disclosed your health information inappropriately.)
    - Using and disclosing your health information for treatment, payment, and health care operations. Information on authorizes to release medical or health information and revoking authorizations.)

Consent for Use and Disclosure of Health Information

I, ___________________________ have had full opportunity to read and consider the contents of the Information on Patient Rights under HIPAA Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to Dental Care Association use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient/Guardian Signature: ___________________________ Today's Date: ________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT UPON REQUEST

Dental Care Association

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection. **<u>Unfortunately, insurance companies to not cover the Oral ID screening. If you op to have the Oral ID Oral Cancer Screening there will be an additional fee of $25, which will be due on day of examination.</u>**

☐ Yes, I request that your staff perform an examination with the OralID for an additional fee of **$25**.

Patient Name: ____________________________ Patient Signature: _________________________

☐ No, I prefer to not have this examination at this visit.

Patient Name: ____________________________ Patient Signature: _________________________

DENTAL CARE ASSOCIATION

PHOTO RELEASE FORM

I hereby authorize Dental Care Association, to publish the photographs taken of me for use in Dental Care Association's printed publications and/or website. I acknowledge that since my participation in publications and websites produced by Dental Care Association is voluntary; I will receive no financial compensation. I further agree that my participation in any publication and website produced by Dental Care Association confers upon me no rights of ownership whatsoever.

By signing below, I release Dental Care Association, its contractors, and its employees from liability for any claims by me or any third party in connection with my participation.

Patient Name: ____________________________ Patient Signature: _________________________

MEDICAL HISTORY

Patient's Name ______________________

Patient's DOB ______________________

Medical Doctor's Name ______________________

Phone # ______________________

Are you currently under the care of a physician? Y N

Explain ______________________

Has there been any recent change in your health? Y N

Explain ______________________

Have you been hospitalized or had serious illness within the past 5 years? Y N

Explain ______________________

Have you ever been treated for AIDS, HIV or any Immune disorder? Y N

Are you pregnant or likely to be pregnant at this time? Y N

# of Weeks __________ OBGYN Dr. ______________

Phone # ______________________

Are you currently taking any prescription, over the counter or recreational drugs? N Y

Please List ______________________

____

____

____

Please mark any allergies **(please circle one)**

Y	N	Aspirin	Y	N	Codeine
Y	N	Penicillin	Y	N	Erythromycin
Y	N	Sulfa	Y	N	Valium
Y	N	Latex	Y	N	Iodine
Y	N	Tretacycline	Y	N	NSAID (Motrin)
Y	N	Local Anesthetics	Y	N	House Bleach
Y	N	Barbiturates	Other ________		

Have you had or do you have any of the following?
(please circle one)

Y	N	Anemia	Y	N	Acid Reflux
Y	N	Angina	Y	N	Asthma
Y	N	Arthritis	Y	N	Bleeding Disorder
Y	N	Bronchitis	Y	N	Cancer / Chemo
Y	N	Diabetes	Y	N	Diarrhea
Y	N	Dizzy / Fainting	Y	N	Epilepsy
Y	N	Glaucoma	Y	N	Head Injury
Y	N	Heart Disease	Y	N	Heart Murmur
Y	N	Hepatitis	Y	N	Migraines
Y	N	Pregnancy	Y	N	Frequent Headaches
Y	N	Infection	Y	N	Kidney Problems
Y	N	Sinus Problems	Y	N	High / Low BP
Y	N	Mouth Ulcers	Y	N	Stomach Problems
Y	N	Claustrophobia	Y	N	Psychiatric Problem
Y	N	TMJ Problems	Y	N	Used Phen Phen
Y	N	Short of Breath	Y	N	STD/Venereal
Y	N	Stroke	Y	N	Ulcers / Colitis
Y	N	Liver Problems	Y	N	Rheumatic/Scarlet Fever
Y	N	Unexplained Weight Loss	Y	N	Increase frequency in urination

Do you have any disease or condition not mentioned above? Y N

Explain ______________________

____
Patient Name (Print)

______________________ ____________
Patient/Guardian Signature Date

______________________ ____________
Dentist Signature Date