HJ DENTAL

It is with the greatest pleasure that I welcome you to our dental practice in Dallas. I appreciate you choosing our practice for your dental needs. Please feel free to ask my dental team any questions and concerns you may have. I also can cover any questions you may have at the time of your visit. I look forward to caring for you and your family's dental needs.

Hours of Operation: Our office is opened Monday, Tuesday, Wednesday and Thursday from 8am to 5pm, Fridays are reserved for surgical procedures only. Emergencies are a phone call away. Office phone number is 214-521-3148 and fax number is 214-521-3186. Our website is dallasdds.net and e-mail address is grin@dallasdds.net.

Appointments: We will make every effort to see you on time. Please arrive at the office 15 minutes before your first scheduled appointment. This will allow the front office staff to do their part prior to the visit. If applicable, please bring your Dental Insurance Card with you at the time of your visit.

Financial Policies: Your payment is due at the time services are rendered. We accept all major credit cards, checks and cash. A returned check will result in a $35.00 fee. **As a courtesy to our patients with dental insurance, we will file your insurance claims. We accept all PPO dental plans. We do our best to ESTIMATE your patient portion with your treatment estimate; however, you will be responsible for any outstanding balance your insurance does not pay. What your insurance will pay is directly dependent on the policy you/your employer chose. The best way to know your insurance policy is to contact your insurance company directly. Your co-pay and insurance portion will be collected at the time of service**. Also, we are happy to offer Care Credit as an option for payment.

My dental team and I are very proud of our full line of dental services and products that we offer, including the dental laser and digital x-ray technology. We look forward to providing you and your family quality dental care in a warm and friendly environment.

Warm Regards,

HJ Dental

9301 North Central Expwy., #585 Dallas, TX 75231 (Tower 2) 214-521-3148

HJ Dental

WELCOME!

PATIENT INFORMATION

Date: _____ ** **E-Mail:** _____
Patient's Name_____ Spouse's Name _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone_____ Cell Phone_____
Birthdate: ____/____/_____ Social Security Number: _____-_____-_____
Employer: _____ Occupation: _____ Male / Female
Height: _____ Weight: _____ Single: _____ Married: _____
If Patient is a minor, parent or legal guardian's name: _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY

Name of person responsible for this account: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone_____ Cell Phone_____
Birthdate: _____ Social Security #: _____ Relationship to Patient _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ Insurance Co.: _____
Insured's Social Security #: _____ Date of Birth: _____
Insurance Co. Phone #: _____ Insurance Co. Address: _____
Insured's Employer: _____Group No. _____ I.D. #: _____
We Do Not File Dual Coverage Insurances.

EMERGENCY INFORMATION

Local Friend or Closest Relative Not living with you: _____
Complete Address: _____
Home Phone:_____ Other Number: _____

DENTAL HISTORY

Reason for visit: _____ Date of last dental visit?_____
Date of last x-rays taken? _____
How often do you brush your teeth? _____Do you have frequent headaches/earaches? _____
Do your gums bleed while brushing / flossing? _____ _____
Gum treatment (Perio)? _____Do you grind or clench your teeth?_____
Are you sensitive to hot, cold, sweets/liquids? _____ Have head, neck or jaw injuries?_____
Do you have any sores or lumps in or near your mouth? _____
Have you noticed any loosening of your teeth? _____
Does food get caught between your teeth? _____
Have you had: Orthodontic treatment (braces)? _____ Oral surgery? _____
Have you ever taken Premeds for any dental treatments? _____
Do you have discolored teeth that bother you? _____
Have you ever had an upsetting experience in a dental office? _____

Updates Initials	Date	Update Address Changes
_____	_____	_____
_____	_____	_____
_____	_____	_____

HJ Dental
Medical/Health History

It is important that I know about your Medical History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Medical History

	Yes	No
Do you have any **CURRENT HEALTH PROBLEMS**?	____	____
Are you under a **PHYSICIAN'S CARE** now?	____	____

For What?_____

_____

What **MEDICATIONS** are you currently taking?_____

_____

Are you **PREGNANT**?	**Yes**	**No**
Do you use cigars/cigarette, pipe, or chewing tobacco?	**Yes**	**No**

Please check of the following which you have had or presently have:

	No	Yes		No	Yes
AIDS/HIV Pos.			Hemophilia(abnormal bleeding)		
Anaphylaxis shock			Herpes		
Arthritis			Hepatitis		
Artificial heart valves			High Blood Pressure		
Artificial joints			Jaw Pain		
Asthma			Kidney disease or malfunction		
Cancer			Liver disease		
Chemical dependency			Mitral valve prolapse		
Chemotheropy			Pacemaker/heart surgery		
Circulatory problems			Radiation treatment		
Cortisone treatments			Respiratory disease		
Diabetes			Shortness of Breath		
Epilepsy			Stroke		
Fainting			Tuberculosis		
Heart murmur			Headaches		
Heart problems			Nervous Disorders		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Asprin____ Local Anesthetic____ Erthromycin____ Latex____ Nitrous Oxide____ Codeine_____ Penicillin_____

Are you aware of being allergic to any other medications or substances? If yes please list _____

_____

Family Physician_____Phone:_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14th, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care and handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies of insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be use for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____date_____do hereby consent and acknowledge my Agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

HJ Dental
9301 N. Central Expwy., Suite #585
Dallas, TX 75231
214 -521 -3148

Important Notice for All Patients

We request that a 48hr. notice be given, if unable to keep your scheduled appointment.

Broken & No Show Appointments

We consider an appointment broken when a patient fails to give a **48 hour notice** or a failure to show up for their scheduled appointment.

1st Missed Appointment – Given as a courtesy, we do understand things sometimes happen that are out of our control. Patients will be notified via telephone, email or text of their first missed appointment. This will be recorded in the patients chart.

2nd Missed Appointment– Due to an increase in patient no shows and last-minute cancellations the office has implemented a no show/cancellation fee of $35. If you cannot make your appointment you must contact our office and cancel 48 hours or more in advance or you will be charged a fee of $35.

Print Patient Name: _____ **Date:** _____

HJ Dental

9301 North Central Expwy., Suite 585, Dallas, Texas 75231

Dear Insured Patient,

As a courtesy our staff will ***assist*** you with your insurance policy. We accept PPO dental insurances and will file claims for your eligible dental services. Insurance is considered a supplemental aid in meeting your dental expenses. Normally, it does not pay everything on some services, and none at all on others. Each patient has individually chosen their policy. Therefore, every plan may differ even though it may be with the same insurance company.

The estimate given to us by your insurance company is not guaranteed, and subject to change. Your **estimated** amount will be due in full at the time the services are rendered. Please keep in mind that you are responsible for any and all charges not paid by your insurance company. It is recommended that you familiarize yourself with your coverage's limits and exclusions.

Insurance claims are filed daily. All claims not paid within 45 days of the date filed are due in full from the patient. This applies even if the claim is in the appeals process. The office will let you know by sending you a statement if any such bills occur. Any unsolved balances past 90 days will be sent to collections. We offer many payment plans to assist you with large balances.

Please remember, it is your responsibility to let our staff know before your scheduled appointment any changes with your insurance status.

I have read and agreed to the above Dental Insurance Policy.

_____

Signature Date