PATIENT INFORMATION

Patient's Name: _____ DOB: (date of birth) _____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Other

*If minor, parent's names & contact #: _____ #: _____

Mailing Address: _____City: _____ State: _____ Zip _____ Email: _

_____Work#: _____Cell#: _____

Home Phone #: _____Preferred Method of Contact (circle one) Text Email Phone Call

In case of emergency, Contact Name & Phone: _____

PRIMARY INSURANCE INFORMATION:

□ Not covered by dental insurance

Primary Insurance Co.: _____ Group/Plan ID#: _____

Subscriber's Name:_____ DOB: _____ SS#: _____

Subscriber's Employer: _____

BILLING INFORMATION: (if different than above)

Name & relationship to patient: _____

Mailing Address: _____ City, State: _____

Zip: _____ Best Contact Phone#: _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check all that apply)

□ Cancer or tumor

□ Heart ailment or angina
□ Heart murmur, mitral valve prolapse, heart defect
□ Rheumatic fever or rheumatic heart disease
□ Artificial joint or valve
□ High or low blood pressure (circle one)
□ Abnormal bleeding after extractions,

□ Hepatitis or other liver disease
□ Alcoholism
□ Blood transfusion
□ Diabetes
□ Neurologic condition
□ Epilepsy, seizures, or fainting spells
□ Emotional condition
□ Arthritis
□ Kidney disease

□ Herpes or cold sores
□ AIDS or HIV positive
□ Migraine headaches or frequent headaches
□ Anemia or blood disorders
□ Pacemaker
□ Hayfever or sinus trouble
□ Allergies or hives
□ Asthma

Are you taking or have you ever taken any of the following?

□ Osteoporosis (bone density) medicine – **Please list:**

_____

_____

List any and all medications you are currently taking:

_____

_____

_____

_____

_____

Are you allergic to, or have you reacted adversely to any of the following?

□ Latex materials
□ Local anesthetics
□ Codeine or other narcotics
□ Antibiotic(s) – **Please list:**

_____

□ Other: _____

Do you smoke or use chewing tobacco? □Yes □No

Women:

□ Pregnant (expected delivery date): _____
□ Taking hormones or contraceptives

Name of Physician: _____ Physician's phone: _____

Please add anything else you would like us to know about (any other diseases, conditions, or problems not listed above?) _____

_____

Signature of patient (or parent/guardian): _____ Date: _____

3517 South Bowen Rd, Dalworthington Gardens TX 76016

Phone: 817-468-3455 Fax: 817-468-3566 Website: *www.jmrogersdds.com*

Email: drrogers@jmrogersdds.com *or* erin@jmrogersdds.com

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign to:

J. Michael Rogers, D.D.S., LLP

3517 South Bowen Rd.

Dalworthington Gardens, TX 76016

All right, title and interest in any payment due me for services as provided in the policy or policies of insurance held by me.

I agree to pay, at Arlington Tarrant County, Texas the charges of J. Michael Rogers, D.D.S., that exceed the amount paid by the policy/ policies held by me.

I further agree and authorize the above-named dentist to release any information requested by the insurance company (s) or its representative.

_____

Date: _____

Name of insurance company: _____

Name of subscriber: _____

Patient name: _____

Patient Signature: _____

J. Michael Rogers, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT **Today's Date:** _____

Name of Patient: _____ If minor, Parent/Guardian Name: _____

Address: _____

Home#: _____ Cell#: _____ Wk#: _____

Email: _____

DOB of Patient (or Parent/Guardian): _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: J. Michael Rogers, D.D.S
3517 South Bowen Rd.
Dalworthington Gardens, TX 76016
817-468-3455 (Office)
817-468-3566 (Fax)
drrogers@jmrogersdds.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

■ CONSENT/SIGNATURE (if minor, Parent/Guardian)

I, PRINT NAME HERE, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: SIGN NAME HERE Date: _____

FILL OUT **ONLY IF**: If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

3517 South Bowen Rd, Dalworthington Gardens Tx 76016

Phone: 817-468-3455 Fax: 817-468-3566 Website: *www.jmrogersdds.com*

Email: drrogers@jmrogersdds.com OR erin@jmrogersdds.com

24 HOUR CANCELLATION & NO-SHOW FEE POLICY

This policy has been established in order to provide the highest level of treatment to all of our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

- Patients must call at least 24 hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within 24 hours of appointment will be considered a late cancellation.
- A $75 fee will be charge for missed or no-show hygiene appointments.
- A $150/hr fee will be charged for missed or no-show treatment appointments with Dr. Rogers.
- We do understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show or late Cancellation Policy will be determined by Dr. Rogers.
- Patients will receive a call, text or email reminders of appointment dates and times 2 business days prior to scheduled appointment (unless patient chooses not to be called).

Patient Name: _____ Date: _____

J. Michael Rogers, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Please note that by signing this form you are acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Printed Name of Patient: _____

Patient DOB (date of birth): _____

If minor, Printed Name of Parent/Guardian: _____

Parent/Guardian DOB (date of birth): _____

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 acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____

_____

_____

Filled out by: _____

Date: _____

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 January 1, 2013, 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 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 our office using the information 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 provider providing treatment to you.

Payment: We may use and disclose your healthcare 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 to 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 or disclosures permitted by your authorization while it was in effect. Unless you give a 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 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 healthcare 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 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 fill 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 healthcare 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 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 have 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. 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 $ _0_ for each page, $_0_ per hour for staff time to locate and copy your health information, 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: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Restrictions: 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS OR CONCERNS

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

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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 you 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: J. Michael Rogers, D.D.S

Telephone: 817-468-3455 **Fax:** 817-468-3566

Email: drrogers@jmrogersdds.com

Address: 3517 South Bowen Rd. Dalworthington Gardens, TX 76016

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