

### Patient Information

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Last, First MI (Preferred Name)

Male  Female  Married  Single  Child  Other \_\_\_\_\_ E-mail Address \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date \_\_\_\_\_ Drivers License # \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T

Address: \_\_\_\_\_

Street

Apartment #

City

State

Zip Code

### Medications

Medication Name      Dosage      Times taken per day

Medication Name      Dosage      Times taken per day

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Initial \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Reason for last dental visit: \_\_\_\_\_

Name of Previous Dentist \_\_\_\_\_ Previous Dentist Phone Number \_\_\_\_\_

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the proceeding answers and information provided are true and correct. I will inform you of any change in my health. I give permission to request information from previous physicians and dentists.

**X** \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient, parent or guardian

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Spouse or Other Responsible Party Information

The following is for:  the patient's spouse or  other person responsible for payment

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date : \_\_\_\_\_ Driver's License \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Employment Information

The following is for:  the patient  the other person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City, \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

### Insurance Information

**Primary**  
Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI  
Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: «PIns Name»  
\_\_\_\_\_

### Consent for Services

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the agreed value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. Financial arrangements must be made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed. In the case of minors of separated or divorced parents, it is the responsibility of the parent bringing the patient into the office to arrange appointments and keep treatment and all accounts current.

I further agree that the fees of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. Complaints concerning dental services can be directed to the State board of Dental Examiners. Or ask to be reviewed by the Fourth District Dental Societies peer review committee.

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company. This office will help prepare my insurance forms or assist in making collections from insurance companies and will credit any such collections to my account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I understand that patient names will be posted in our appointment books, on computer screens, and on schedules posted in treatment areas of the office, and that patient privacy will be maintained as much as possible.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to my treatment and billing. I understand that I may receive a text message to remind me of an appointment the day of my scheduled appointment. \_\_\_\_\_ (Please initial)

I have read the above conditions of treatment and payment and agree to their content.

**X** \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Signature of patient, parent or guardian

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Zip: \_\_\_\_\_

## 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: Donald W. Lanning DDS Telephone: 940-464-3500 Fax: 940-464-3502 E-mail: [office@drlanning.com](mailto:office@drlanning.com) Address: PO BOX 369 Argyle, TX 76226-0369

**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 that 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.

**SIGNATURE**

I, \_\_\_\_\_ 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: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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

\_\_\_\_\_  
DATE \_\_\_\_\_

{Signature}

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) \_\_\_\_\_

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# Donald W. Lanning DDS PA

## 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 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 us using the information listed 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 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 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 us 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 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:** When we are required to do so by law, we may use or disclose your health information

**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 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

You have the right to look at or get copies of your health information, with limited exceptions. We will use the format you request unless we cannot practicably do so. There may be a small cost involved in staff time and materials for copying your health information. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

**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, for the last 6 years, 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.

**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 a detailed request in writing.

**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.

### **QUESTIONS AND COMPLAINTS**

If you have questions or concerns or would like more information about our privacy practices, 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 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 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 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.

**CONTACT OFFICER:** Donald W. Lanning DDS  
**TELEPHONE:** 940-464-3500 **FAX** 940-464-3502  
**E-MAIL ADDRESS:** office @ ArgyleDentalConnection.com  
**ADDRESS:** 415 Hwy 377 S, Ste 201, Argyle, TX 76226