Patient Registration

First Name* Middle Name Last Name *

_____ _____ _____

Date of Birth * _____

Gender ○ Male ○ Female ○ Prefer not to say Marital Status _____

Address * _____

City * _____ State * _____ Zip * _____

CONTACT INFORMATION

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

How did you hear about us? _____

Do you consent to receiving any updates/appointment reminders? ○ Email ○ Text ○ Both

RESPONSIBLE PARTY INFORMATION

☐ SAME AS ABOVE

Relationship to Patient* _____

First Name* Middle Name Last Name *

_____ _____ _____

Date of Birth * _____

Address * _____

City * _____ State * _____ Zip * _____

Medical History

PATIENT DETAILS

First Name* Middle Name Last Name *

_____ _____ _____

Date of Birth * _____

Gender ○Male ○Female ○Prefer not to say

HEALTH HISTORY

Are you currently under the care of a physician? ○Yes ○No
Physician Name:
Physician Phone Number:

Have you ever been hospitalized or had a major operation? ○Yes ○No
If yes, please explain:

How would you rate your physical health? (Please circle one)

Good Fair Poor

Have you undergone placement of any metal rods, pins, or implants? ○Yes ○No
If yes, please explain:

Have you ever had a serious head or neck injury? ○Yes ○No
If yes, please explain:

Do you take, or have you taken, Phen-fen or Redux? ○Yes ○No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○Yes ○No
If yes, please explain:

Do you use tobacco in any form? ○Yes ○No

Do you use controlled substances? ○Yes ○No
If yes, please explain:

Are you on a special diet? * ○Yes ○No
If yes, please explain:

MEDICAL HISTORY

Do you have allergies to any of the following?

- ❑Aspirin
- ❑Acrylic
- ❑Codeine
- ❑Latex
- ❑Local Anesthetics
- ❑Metal
- ❑Penicillin
- ❑Sulfa Drugs
- ❑Other:
- ❑ NO ALLERGIES

If you answered "Other" please specify/explain:

Do you have, or have you had any of the following medical conditions?

- ❑Anemia
- ❑Arthritis
- ❑Artificial Joints
- ❑Asthma
- ❑Blood Disease
- ❑Cancer
- ❑Diabetes
- ❑Dizziness
- ❑Epilepsy
- ❑Excessive Bleeding
- ❑Fainting Glaucoma
- ❑Head Injuries
- ❑Heart Disease
- ❑Heart Murmur
- ❑Hepatitis
- ❑High Blood Pressure
- ❑HIV
- ❑Jaundice
- ❑Kidney Disease
- ❑Liver Disease
- ❑Mental Disorders
- ❑Nervous Disorders
- ❑Pacemaker
- ❑Pregnancy
- ❑Radiation Treatment
- ❑Respiratory Problems
- ❑Rheumatic Fever
- ❑Rheumatism
- ❑Sinus Problems
- ❑Stomach Problems
- ❑Stroke
- ❑Tuberculosis
- ❑Tumors
- ❑Ulcers
- ❑Venereal Disease
- ❑Other

If you answered "Other" please specify/explain:

Are you currently taking any of the following medications?

- ❑Aspirin
- ❑Penicillin
- ❑Codeine
- ❑Pre-Med - Amox
- ❑Pre-Med - Clind
- ❑Pre-Med - Other

If you answered "Other" please specify/explain:

Patient Signature: _____ Date: ____/____/_____

Hulen Smiles

GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE: I understand that I may be having the following work done: Dental exams, X-rays, Fillings, Cleaning, Fluoride, Scaling & Root Planning, Sealants, Space Maintainer, Night Guard, Pulpotomy, Crown, Bridge, Veneers, Reline, Partial Denture, Denture, Bleaching or any other needed treatment.

2. DRUGS AND MEDICATION: I understand that I will be given antibiotics if needed. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.

3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.

4. EMERGENCY VISIT: I understand that the treatment provided by my dentist is intended to ONLY eliminate or reduce the infection and/or pain that I am currently experiencing and may not be definitive care. There may be a need for additional procedures to return the state of my mouth to optimum health. Failure to seek additional treatment that my doctor recommends may result in further issues, including pain, infection, and loss of teeth/bone and/or function.

5. PREGNANT: If in any case, I am pregnant or am thinking to be pregnant, I will inform my dentist before any dental procedure.

INFORMED CONSENT: I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I hereby authorize any of the dentists/dental auxiliaries to proceed with and perform the dental restorations/treatments as explained to me. I understand that my treatment plan is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Signature of patient/Guardian _____

Financial Policy

Please read this Financial Policy carefully, then sign to acknowledge your understanding and agreement to the terms of the Financial Policy. Thank you for choosing us as your dental care provider. We are committed to providing you with dental care available.

Available Payment Options: **Cash, Check, Visa, Mastercard, American Express, CareCredit**.
We also offer a payment plan option; please ask us for further information regarding this option.

Insurance: Coverage and Co-pays
*** For covered services, all co-pays and deductibles must be paid on the day of treatment.** Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment.

*** For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment**

***** We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance
*** For those patients without insurance coverage, you will be responsible for payment on the day of treatment.** If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy
***** Our office requires at least 48 hours advance notice to cancel your appointment in the case of an emergency.

*** We reserve the right to charge a reasonable fee, up to the amount of $30 or fees due for our services, for patients who do not give advance notice to cancel an appointment.**

Collections
***** A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

X-Rays
***** You are responsible to pay a fee for duplicate copies of your X-rays.

I hereby authorize payment to Hulen Smiles in Fort Worth, TX by my insurance company, otherwise payable to me.

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

HIPAA & Notice of Privacy Practices

PATIENT DETAILS

First Name* _____ **Middle Name** _____ **Last Name *** _____

Date of Birth * _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by 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 will follow the privacy practices that are described in 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. 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 the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to 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.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our 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.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care 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 health care 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 a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally 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 health care or with payment for your health care, but only if you agree in writing 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, concerning 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 (1) 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 and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up 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 health 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 may be a 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 official's 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 of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request 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. You may also request access by sending us a letter to the address at the end of this Notice.

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, health care operations and certain other activities, for the last 6years. We will provide such a list at no charge upon your request once in any 12month period. We reserve the right to charge you for requests in excess of one per 12month period.

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. (Any such 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 upon your request.

QUESTIONS AND COMPLAINTS

To learn more 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 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 contact us using the contact information listed below. 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 and 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.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

If patient is a minor,

Guardian's relationship to patient: _____

Address * _____

City * _____ State * _____ Zip * _____
***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

Patient/Guardian Signature: _____ Date: _____

HULEN SMILES

Preferred Pharmacy information:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Please answer a few questions.

1) What are your concerns today? _____
2) Are you happy with your smile? _____
3) What do you not like about your smile? _____
4) Are you interested in teeth whitening? _____

We are here to serve our patients with excellent dental services. So, if you have any family members or friends that need dental services, please write their information and we would contact them.

Referrals:

1) Name and Phone Number:

   _____

2) Name and Phone Number:

   _____

HULEN SMILES

NO SHOW POLICY

Our goal at Hulen Smiles is to provide quality service to all of our patients in a timely manner. Failure to keep scheduled appointments is costly to both the clinic and you as a patient.

This letter is to inform you of our policy concerning “No Shows”. Patients who are unable to keep their appointments are requested to give 24-hour notice prior to their appointments. We realize this is not always possible and the practice will consider each individual case. Providing such notice allows the clinic time to offer other persons the opportunity to see our providers, thus using the time more efficiently. If an established patient fails to provide notice, it will be necessary to charge them a $30.00 fee that will be billed to his/her account. If a patient has confirmed his/her appointment and fails to keep that appointment, there will be a $30.00 fee billed to his/her account. If a patient fails to keep his/her appointments on a regular basis, or has missed 3 consecutive appointments, he/she will be considered dismissed from the practice, and a letter of dismissal will follow.

I have read and understood this policy, and accept this responsibility of its terms effective on February 24, 2023.

Patient Signature _____

Date _____

Video Consent and Release Form

Without expectation of compensation or other remuneration, now or in the future, I hereby give my consent to **Hulen Smiles**, to use my image and likeness and/or any interview statements from me in its publications, advertising or other media activities (including the Internet).

This consent includes, but is not limited to: (Initial where applicable)

_____ - (a) Permission to interview, film, photograph, tape, or otherwise make a video reproduction of me and/or record my voice;

_____ - (b) Permission to use my name; and

_____ - (c) Permission to use quotes from the interview(s) (or excerpts of such quotes), the film, photograph(s), tape(s) or reproduction(s) of me, and/or recording of my voice, in part or in whole, in its publications, in newspapers, magazines and other print media, on television, radio and electronic media (including the Internet), in theatrical media and/or in mailings for educational and awareness.

This consent is given in perpetuity, and does not require prior approval by me.

Name: _____

Signature: _____

Date: _____

The below signed parent or legal guardian of the above-named minor child hereby consents to and gives permission to the above on behalf of such minor child.

Signature of Parent or Legal Guardian: _____

Print Name: _____

Date: _____