

Patient Name: _____ Date _____
____ Male ____ Female ____ Married ____ Single ____ Child ____ Other Birthdate _____
Social Security# _____ Drivers License # _____ State _____
Home Phone# _____ Work _____ Ext: _____ Best Time to call _____
Cell Phone: _____ E-Mail _____ Fax# _____
Address: _____
City: _____ State: _____ Zip: _____

Previous Dentist: _____ Date of last Dental Visit: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

<input type="checkbox"/> Aids	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Latex Sensitivity	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Tumors
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Growths	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Codeine Allergy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Psychiatric/ Psychologiacal Care	<input type="checkbox"/> Penicillin Allergy
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Radiation treatment	Allergic reaction to Medication
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Respiratory Problems	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart(attack, disease, surgery)	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Cold Sores/Fever Blisters	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Sinus Problems	_____
<input type="checkbox"/> Cortisone Medication	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Smoke/ Chew Tobacco	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach Problems	_____
<input type="checkbox"/> Diet(restricted/special)	<input type="checkbox"/> Jaundice		

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 _____

Name of Physician: _____ Phone: _____

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

Are you taking any medications? Please List _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature _____ Date _____

Date _____

Cosmetic Information

Is there anything about your smile that you do not like? _____

Are you interested in knowing the options available for a more beautiful smile? _____

Do you like the appearance of your teeth? _____

Are all of your teeth in alignment (straight)? _____

Do you have any missing teeth? _____ Are any chipped? _____

Is your bite comfortable when chewing, biting? _____

Do you have frequent headaches? _____

Do you have any old fillings or dental treatment that you are unhappy with? _____

What would you like to change the most about the appearance of your teeth? _____

Is there anything else that you would like us to know? _____

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another Doctor Dental Office
 School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

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

Name: _____

Male Female Married Single Child Other _____

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 person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____ Street _____ City _____ State _____ Zip Code _____

General Consent For Treatment

We are required to obtain your consent for contemplated or proposed dental treatment or oral surgery. Please read this form carefully and we encourage you to ask us about anything that you do not understand. We will be glad to explain it to you.

1.1, hereby authorize and direct Christian Family Dentistry Decatur, or any of its subsidiaries, assisted by licensed dentists and / or dental auxiliaries of their choice to perform upon me, or my child (name) _____ the following dental treatment or oral surgery procedures including the necessary or advisable local anesthesia, radiographs(x-rays) or diagnostic aids.

2. In general terms, the dental procedures may include one or a number of the following:

- A cleaning of the teeth and application of topical fluoride.
- Application of sealants to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
- Stainless steel crowns for children. These are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities.
- The replacement of missing teeth with a dental prosthesis (crown, partials etc.).
- Extraction (removal) of one or more teeth that cannot be saved.
- Treatment of diseased or injured oral tissues (hard and / or soft).
- Treatment of malposed (crooked) teeth and / or developmental abnormalities.
- The use of sedative medications and / or nitrous oxide to control apprehension and / or Disruptive behavior.

The treatment has been explained to me. I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any have been explained to me, as have the advantages and disadvantages of each. I am advised that good results are expected; however, the possibility and nature of complications cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to perform any necessary treatment that in his / her judgment will be in the best interest of me or my child's health, once treatment has been initiated.

3. Although their occurrence is rare and unpredictable, some risks are known to dental or oral surgery procedures, medication and / or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, and scarring.

I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time: that I choose to terminate. Such termination of consent must be in writing.

Patient Name: _____

Signature of Patient / Guardian: _____

'Witness: _____ Date: _____

Consent to Disclose Private Healthcare Information

For Treatment, Payment, and/or Healthcare operations

I _____, hereby authorize and consent for Christian Family Dentistry to release any and all medical, dental, and or psychological reports or records, including but not limited to; medical/dental notes, physician narratives, office notes, operative notes, discharge summaries, Doctor's / Dentist's orders. Nurse's notes, lab reports, test results, physical therapy, progress notes, patient progress reports, diagnosis, post operative diagnosis, pathology reports, x-ray and any records reflecting treatment for substance abuse, mental illness, AIDS, HIV, alcohol abuse, including any X-ray diagnostic studies, lab slides, clinical abstract, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental conditions, treatment, care, or hospitalizations, and any other personal health information regarding my medical/dental care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

I understand that the operations of the office of Christian Family Dentistry, is being visually and orally recorded by a virtual private network. I hereby authorize and consent to such recording.

The release of the matters listed above is being authorized for purposes of obtaining medical/dental treatment, payment for such services and other healthcare options.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review Christian Family Dentistry's privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signature _____ Date _____

Christian Family Dentistry Decatur

Date: _____

Name: _____

Christian Family Dentistry accepts dental insurance and files claims as a courtesy for it's patients.

In some instances, the insurance company will send payment of benefits to you in error instead of to Christian Family Dentistry. By your signature below, in such event, you agree to immediately send all such benefits personally received to Christian Family Dentistry Decatur.

You understand that the retention of such monies rightfully due may constitute a criminal offense.

AGREED AND ACCEPTED

Signature _____ Date: _____

Christian Family Dentistry INC PC

2100 S. Reeves LN/Decatur TX, 76234/940-627-8400

WRITTEN FINANCIAL POLICY

Thank you for choosing Christian Family Dentistry Inc. PC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS:

You can choose from:

- cash, check, visa, MasterCard or Discover card
- convenient monthly payment plans¹ from care credit
 - Allow you to pay over time
 - No annual fees or per-payment penalties

PLEASE NOTE:

Christian family Dentistry Inc. PC requires payment at the time of your treatment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment². The payment we receive from you in our office is just an estimate, if insurance pays less than what has been estimated or fail to pay their portion of payment; we will send you the bill.

Christian Family Dentistry Inc. PC charges \$25.00 for returned checks. If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (please Print)

¹ Subject to credit approval

² However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.



Acknowledgement of Receipt of Notice of Privacy Practices Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.

Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date

Time

Print Patient's Full Name

Witness Signature

Notice of

Privacy Practices



OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/2013, 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 the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it 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.

Your Authorization: In addition to our use of your health information for the following purposes, 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may 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. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare

reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You Or Your Personal Representative: 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 your personal representative, 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 absence or incapacity or in 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.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

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.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

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

institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters).

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. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you \$25.00 for each page, \$20.00 per hour for staff time to 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: 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health

request must specify the alternative means or location, and provide satisfactory explanation of 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: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

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 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:

**DR. CHRISTIAN NWOKORIE
CHRISTIAN FAMILY DENTISTRY**

2100 REEVES ROAD
DECATUR TX 76234

940-627-8400
christianfamilydentistry.net

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <small>Patients who are well but who have a known COVID-19 infection at home with COVID-19 should consider postponing elective treatment.</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.