HEALTH QUESTIONNAIRE FOR e-DENTAL GROUP

****CONFIDENTIAL****

Patient's Full Name _____ **Preferred Name** _____

Patient's Birth Date_____ **Social Security** _____ **Male** ___ **Female** ___

Home Phone _____ **Work** _____ **Cell** _____

Address _____ **City** _____ **State** ___ **Zip Code** _____

Email _____ **Would you like reminders by email? Y**___ **N**___

Patient's Physician _____ **Physician's Phone** _____

Patient's Dentist _____ **Patient's Orthodontist** _____

Emergency Contact _____ **Phone Number** _____

REFERRAL INFORMATION

Whom may we thank for referring you to e-dental? _____

A patient ____ **Friend** ____ **Relative** ____ **Insurance** ____ **Web page** ____ **Yellow pages** ____ **Newspaper**_____

Have you had any of the following?

__ Anemia
__ Anxiety
__ Arthritis/Rheumatism
__ Artificial heart valve
__ Artificial joint
_____
__ Asthma
__ Benign growths
__ Bisphosphonate meds. (fosamax, boniva, actonel)
__ Blood vessel grafts
__ Bronchitis
__ Cancer_____
__ Radiation treatment
__ Chemotherapy
__ Cirrhosis
__ COPD
__ Cortisone/ACTH
__ Cough or flu
__ Depression
__ Diabetes I or II
__ Difficulty opening
__ Emphysema
__ Excessive bleeding
__ Fainting
__ Glaucoma
__ Head injuries
__ Heart attack
__ Heart failure
__ Heart murmur
__ Heart surgery
__ Heart trouble
__ Hemophilia
__ Hepatitis A, B, C
__ High blood pressure
__ HIV/AIDS
__ Hyperthyroid
__ Immune deficiencies
__ Irregular heart beat
__ Jaundice
__ Kidney disease
__ Liver disease
__ Loud snoring
__ Low thyroid
__ Thyroid removal
__ Replacement therapy
__ Lung disease
__ Mitral valve prolapse
__ Nasal obstruction
__ Nervous disorders
__ Organ transplant
__ Pacemaker
__ Pregnancy- currently
Due Date_____
__ Psychiatric treatment
__ Recent illness
__ Rheumatic fever
__ Seizures/epilepsy
__ Shortness of breath
__ Sinus problems
__ Stomach problems
__ GERD
__ Ulcers
__ Stroke
__ TMJ problems
__ Tuberculosis
__ Venereal disease

ARE YOU ALLERGIC TO:

__ Aspirin
__ Barbiturates
__ Codeine
__ Eggs or egg whites
__ Latex
__ Novocain- local anesthetics
__ Penicillin/Amphicillin/Amoxicillin
__ Sulfa drug

Adverse reaction to any other:

_____

Other health problems not listed:

_____

_____

Office Use Only

BP: _____

PR: _____

YES	NO	
__	__	Are you in good health?
__	__	Are you having pain or discomfort at this time?
__	__	Have you had a bad experience with previous dental or surgical treatment?
__	__	Have you been under the care of a physician or hospitalized during the past two years? If yes, explain_____
		_____
__	__	Have you ever gone to sleep for an operation? If yes, explain. Any complications?_____
		_____
__	__	Have you ever had any complications following dental treatment? If yes, explain_____
		_____
__	__	Have any immediate family members had a serious reaction to a general anesthetic? _____
__	__	Are you taking medicines of any kind, including aspirin, diet pills or vitamins? Please list:
		_____
		_____
__	__	Have you ever used recreational or IV drugs (marijuana, cocaine, etc.) or Phen/Fen? Please list: _____
__	__	Do you smoke or use smokeless tobacco? If yes, how long _____ How much per day?_____
__	__	Do you wear dentures/partials?
__	__	Do you wear contacts?
__	__	Have you undergone eye surgery in the past 8 weeks?
__	__	Do you have a specific dental problem you would like to address?_____
		_____
__	__	Do you have dental exams on a regular basis?
__	__	Are your teeth sensitive to: cold_____ hot_____ sweet_____ biting_____ touch_____
__	__	Do you think you have active decay?
__	__	Do you think you have gum disease?
__	__	Do your gums bleed?
__	__	Have you been taught how to control gum disease?
__	__	Do you brush your teeth? How often: twice daily__ once daily__ weekly__ not regularly__
__	__	Do you floss your teeth? How often: twice daily__ once daily__ weekly__ not regularly__
__	__	Have you had: scaling or root planing__ gum surgery__ TMJ therapy__surgery__ braces__
__	__	Do you clench or grind your teeth?
__	__	Do you wear a grinding guard/night guard?
__	__	Do you have clicking or popping in your jaw joint?
__	__	Do you have human papillomavirus (HPV) or a history of HPV?
__	__	Do you have any sores, ulcers or growths in your mouth?_____
__	__	Do you drink alcoholic beverages? If yes how often? Never__ seldom__ more than 2 a day__
__	__	Do you have fear of dental treatment?
__	__	Are you pleased with the appearance of your teeth?
__	__	Would you like to have your teeth whitened?
__	__	Do you think you have bad breath?
__	__	Are you under the care of a Physician? Please explain:_____
		_____
		_____
		Describe any other changes you would like in the appearance of your teeth: _____
		_____
		_____
		Do you have any other information you think we should know about? _____
		_____
		_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in health status, or if my medications change, I will inform the doctor accordingly.

Patient Signature: _____

Dentist Signature: _____

RESPONSIBLE PARTY INFORMATION

☐ **Check Here if the responsible party is the patient. Otherwise, please fill out the Responsible Party Information below.**

Full Name _____ Date_____

Social Security Number _____ Birth Date_____

Home Phone _____ Cell _____ Work _____

Address, if different than patient's _____

EMPLOYMENT INFORMATION

The Following is for: The Patient _____ or The Person Responsible for Payment _____

Employer Name _____ Occupation _____

Address _____

INSURANCE INFORMATION

Primary name of Insured _____ Is insured a patient? __yes __no

Patient's relationship to Insured? Self ____ Spouse ____ Child ____ Other _____

Insured's Birth date _____ ID # _____ SS# _____ Group # _____

Insured's Address _____

Insurance Plan Name and Address _____

_____ Ins. Co. Phone Number _____

Secondary
Name of Insured _____ Is insured a patient? __yes __no

Patient's relationship to Insured? Self ____ Spouse ____ Child ____ Other ____

Insured's Birth date _____ ID # _____ SS# _____ Group # _____

Insurance Plan Name and Address _____

_____ Ins. Co. Phone Number _____

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our financial administrator depending upon special circumstances. An estimate of charges for any procedure will be given to you upon request. If you have insurance, we will be happy to submit the claims, but it is your responsibility to provide the needed information. Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor, and it is not a substitute for payment. Some companies pay fixed allowances for procedures while other companies pay a percentage of their allowance. It is your responsibility to pay any deductible, co-payment, percentage of charges your insurance does not cover.

This signature on file is my authorization for the release of information necessary to process my claim, and provide information and/or x-ray copies to my referring doctor (s) regarding my treatment. I hereby authorize payment directly to the doctors named on the insurance benefits, otherwise payable to me. If I fail to pay as promised, I agree to pay all reasonable costs and attorney fees. I have read the Patients' Rights and Responsibilities Statement.

SIGNATURE _____ 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 THIS 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.

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 make the new notice available upon request.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operation. 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 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 qualification 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 anytime. Your revocation will not affect any use or disclosure 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 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.

Person 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, or 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: 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 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 a 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

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 $25.00 to cover the cost of each page, and 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 structures.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for the 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 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 website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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: Althea A. Eggleston, DDS, PA or Dr. Todd I. Eggleston DDS

Telephone: 512-637-8989 **Fax:** 512-391-0031

Address: 1209 W. 5th Street, Suite #100 Austin, TX 78703

ACKNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT

I have been made aware of the HIPPA Privacy Practices Notice for E Dental Group at 1209 W. 5th Street, Suite #100-B.

X_____
Print Name of Patient Date

X_____
Signature of Individual Date

PRACTICE POLICIES

Financial Responsibility

-Payment for services are due at the time of your appointment.

-We process your payment by personal check as an electronic debit. For any reason your check is not authorized through Retriever, another form of payment is due at the time of your appointment.

-For balances not paid within 30 days of statement date, the account will be sent for collection.

Insurance

I authorize release of any dental information necessary to process insurance claims. I also request payment of benefits to be made to Dr. Althea Eggleston, DDS, PA.

Insurance Claims: Providing quality medical care for our patients is our primary concern. It is extremely difficult to keep track of all insurance plans requirements. Each plan has different guidelines regarding benefits provided. If you do not inform us of any special requirements in your contract and we order services that are not covered, we will have no choice but to bill you directly for those charges. You are responsible for your own insurance.

Quotes given for proposed treatment are just an estimate. Balances remaining after insurance pays is your responsibility and due within 30 days of the issued statement.

Missed Appointment Policy

Our practice is dedicated to quality care and exceptional service. We spend extensive amounts of time preparing for your visit. Broken and missed appointments result in financial hardship for our office and create scheduling problems for other patients. If you find that you must change your appointment, we require a minimum of 24 hours notice so that we may make every effort to accommodate other patients.

-If proper notice is not received, a fee of $50 will be charged for every hour of allotted time cancelled.

Consent for Treatment

-I hereby authorize doctor or designated staff to take radiographs, dental impressions, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs

-Upon such diagnosis I authorize doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.

-I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I HAVE READ AND UNDERSTAND THE "PRACTICE POLICIES"

_____ _____

Patient Signature Date