Gary N. Pointer, DDS

PATIENT INFORMATION

(this information is necessary for our files and is strictly confidential)

Patient's Last Name: ______________________________ First Name: ____________________ Middle: ________

Home Phone: (   ) __________________ Cell Phone: (   ) ________________ Fax: (   ) __________________

Email Address: ____ Do you check it regularly? Yes _____ No _____

Home Address: ____

Street   City   State   Zip

Date of Birth: ______________ Social Security No.: ________________ Driver's License No.: __________________

If a student, name of school: ____________________ Whom may we thank for referring you? ____________________

Place of Employment: ____

Employer's Address: ____

Occupation: ____ Work Phone: (   ) ___________________

FINANCIAL INFORMATION

Name of Person Responsible for this Account: __________________________________ Relationship: ____________

Street Address: ____ Phone: (   ) ___________

Street   City, State, Zip

Social Security Number: ____________________________________ Date of Birth: _______________________

Place of Employment: ____ Work Phone: (   ) _________________

Employer's Address: ____

Is this patient currently a patient in our office: Yes _______ No _______

DENTAL INSURANCE

Insured Person's Full Name: __________________________________ Date of Birth: ____________________

Social Security Number: ________________________ Relationship to Patient: ______________________________

Insurance Company Name: ______________________________ Group ID Number: ________________________

Insurance Company Mailing address for Dental Claims: ____

Employer Name: _____________________________ Is there dual coverage for dental claims? Yes ______ No ______

FOR YOUR INFORMATION

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient named above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedures involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also understand and agree that any all past due balances over thirty days will be subject to a 1.5% finance charge per month as allowed by Texas state law.

____

Signature of Patient or Responsible Party   Date

Gary N. Pointer, DDS

HEALTH QUESTIONAIRE

(this information is necessary for dental treatment and is strictly confidential)

Patient Name: ____

Name of Physician:____Date of last physical: __________________

City: ____Physician's phone number: (   ) ____________________

Are you allergic to : **Penicillin:** **Yes: ________ No:_________**
Codeine: **Yes: ________ No: _________**
Local Anesthetics: **Yes: ________ No: _________**
Latex: **Yes: ________No:__________**

Other known allergies:____

Have you had any **disease**, i.e. AIDS, HIV, drug or transplant operation that has depressed your immune system?
Yes:________No:__________

Do you have Hepatitis: Yes:________No:__________
If yes, which type: _________________________

Venereal Disease/Herpes: Yes:________No:__________

If female, are you pregnant? Yes: ________No:__________

Have you ever had any prosthetic joint replacements? (Hips, shoulders, knees, etc.)
Yes: _____No:_____

If yes, please explain:
____

Do you have a heart murmur or mitral valve prolapse? Yes: ________ No: _________

Other health complications we should be aware of: ____

Do you wish to speak privately with Dr. Pointer about anything? Yes:__________No:__________

Please list any and all medications you are currently taking and the reasons you are taking those meds:
____
____

Please list any other medical condition you feel Dr. Pointer should be aware of: ______________________________
____

Please answer all by checking yes or no:	***YES***	***NO***
Heart Problems	_____	______
High Blood Pressure	_____	______
Low Blood Pressure	_____	______
Circulatory problems	_____	______
Rheumatic Fever	_____	______

Page two
Health Questionaire

Patient Name: ____

	YES	***NO***
Diabetes	______	______
Radiation Treatments	______	______
Epilepsy	______	______
Kidney Problems	______	______
Nervous Problems	______	______
Tuberculosis	______	______
Excessive Bleeding	______	______
Cerebral Palsy	______	______
Scarlet Fever	______	______
Malignancies/Cancers	______	______
Chronic Sinus	______	______
Chronic Ear Problems	______	______
Anemia	______	______
Arthritis	______	______
Adenoids removed	______	______
Tonsils removed	______	______
Asthma	______	______

Name of Previous Dentist: ___________________________________City/State:_____________________________________

Date of last visit: _____________________________________Reason for last visit:_____________________________________

Are you sensitive to: Heat: ______ Cold:________ Sweets: ________ Chewing/Pressure:________

Have you had any injuries to the mouth/jaw area? ____

When were your last dental x-rays? _____________When was your last cleaning and exam?________________________________

Do your gums bleed or feel tender or irritated? Yes:_____ No:______

Have you ever had periodontal treatments/surgery? Yes: _____ No:______

If Yes, please explain: ____

Do you smoke or use tobacco products? Yes:________ No:_________

Do you wear dentures/partials? Yes:______No:________

Are you aware of grinding or clenching your teeth? Yes:_______ No:_______

Do you have discolored teeth that bother you? Yes:_______ No:_______

Are there any other dental concerns you would like Dr. Pointer to be aware of:____

____

I hereby acknowledge that I have provided the above health information to Dr. Gary Pointer and that it is true and accurate.

____

Patient Signature or Guardian Relationship Date

Gary N. Pointer, DDS

Assignment of Insurance Benefits

In consideration of services rendered, I hereby transfer and assign to Gary N. Pointer, DDS, 4901 Bryant Irvin Rd. North, Fort Worth, Texas, all right, title and interest in any payment due for services as provided in the policy or policies of dental insurance held by me.

I agree to pay, at Fort Worth, Tarrant County, Texas the charges of Gary N. Pointer, D.D.S., which exceed the amount paid by the insurance policies held by me. I further agree and authorize Gary N. Pointer, D.D.S., to release any information requested by the insurance company(s) or its representatives. I understand that filing of my dental insurance is done as a courtesy to me.

Authorization for Treatment

I hereby authorize Gary N. Pointer, D.D.S., to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient named below and further authorize and consent that Dr. Gary Pointer chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by Dr. Pointer and /or his staff. I further authorize the use of any study models, photographs or radiographs taken by Dr. Pointer to be used by him for educational or teaching purposes.

Agreement to Pay for Services Rendered

I agree to pay for all services rendered by Dr. Gary N. Pointer. I further understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance. I also understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% (18% annually) per month, as allowed by the laws of the State of Texas.

I also acknowledge that I have received a copy of the Notice of Privacy Practices (HIPAA).

I hereby authorize Gary N. Pointer DDS, to release dental information regarding myself by mail, on my answering machine or voice mail. Patient's Initials: _____________

Print Name of Patient: ____________________________________

Authorized Signature: ____Date: _______

I hereby authorize Gary N. Pointer, DDS to release dental/medical information regarding myself to the following:

Name:	Relationship	Phone #	Patient Initials

Gary N. Pointer, DDS

Financial Policy for Our Patients

Insurance

Our office accepts all traditional indemnity dental insurance. We do not participate in any DMO/HMO dental plans or any reduced fee schedule plans.

We understand the value of your dental insurance and are happy to file your dental claims on your behalf. We will gladly accept assignment of your benefits – this means that you must agree to assign your benefits to us so that we may receive payment from your dental insurance carrier. We will complete and process all insurance forms for you.

Most dental insurance plans do not cover 100% of the cost of any treatment. Because of this, and a delay in receiving payment from your insurance carrier, you will be asked to pay your deductible as well as your estimated copayment at the time professional services are rendered. We will estimate as closely as possible your coverage but until we actually received payment from your carrier, it is just that – an estimate.

Please understand that we file and accept assignment of your insurance benefit as a courtesy to you. If your insurance denies coverage or does not pay for any reason, you are ultimately responsible for any and all charges.

Payment Options

Our office accepts cash, personal checks and all major credit cards for services. We do not finance any dental work ourselves. For those patients who require a little extra time to pay for services, we work with CareCredit. CareCredit can be reached at 800-839-9078 for further questions.

Cancellation and No Show Policy

We understand that schedules sometimes change. *If you need to change or cancel an appointment, a 24 hour notice is required. Please be advised our office is closed on Fridays. If 24 hours advance notice is not provided, a fee of $50 will be charged.* This fee may be higher for longer appointments. For complex cosmetic and implant procedures, a deposit may be required in order to secure your appointment. Thank you for your understanding.

I have read and understand the above office policies.

____

Patient or Authorized signature Date

Gary N. Pointer, D.D.S. • (817) 737-2531

Protecting Your Confidential Health Information is Important to Us

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.

Our Promise!

Dear Patient:
This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA - Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s): ______________________________

____

____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

____
Patient Signature
Date ______/______/______

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

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