MONTZ and MAHER DENTAL GROUP

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name →	Middle Name	Last Name	Preferred Name
Home Address →	City	State	Zip
Social Security Number →		Drivers License Number	Date of Birth
Home Phone →	Cell Phone	Email	
Occupation →	Employer Name	Employer Phone	
Employer Address →	City	State	Zip

Person Responsible For Account ~ ☐Check Here If Same As Above

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name →	Middle Name	Last Name	Preferred Name
Home Address →	City	State	Zip
Social Security Number →		Drivers License Number	Date of Birth
Home Phone →	Cell Phone	Email	
Occupation →	Employer Name	Employer Phone	
Employer Address →	City	State	Zip

Dental Insurance Information

☐Check here if you do not have Dental Insurance ☐Check here if you previously provided information

Insured's First & Last Name →	Date of Birth	Social Security
Name of Insured's Employer →		Patient Relationship To Insured
Insurance Company →	Phone	Subscriber ID #	Group ID #
Insurance Company Address →	City	State	Zip

Referral Information

How did you **first** hear about our office? ☐Another Patient (relative) ☐Another Patient (friend) ☐New Patient Flyer

☐Another Dental or Medical Office ☐School ☐Work ☐Church ☐Drive By Office ☐Google ☐Yelp ☐Yahoo

☐Yellow Pages ☐Employee ☐Community/Charity Event ☐Insurance Company ☐Health/Benefits Fair or Event

If you were referred to us by someone please write their name.

Montz and Maher Dental Group

Family, Cosmetic, Sedation and Implant Dentistry

Dental Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Please check Yes or No for those that apply to you.

YES	NO		YES	NO	
☐	☐	Sensitivity to: Hot Cold Sweet	☐	☐	Bleeding, Swollen or Irritated Gums
☐	☐	Chipped / Broken Teeth	☐	☐	Dissatisfied With Appearance of My Teeth
☐	☐	Crooked or Tipped Teeth	☐	☐	Frequent Headaches
☐	☐	Loose Teeth	☐	☐	Jaw Joint Pain
☐	☐	Missing or Spaces Between Teeth	☐	☐	Grinding or Clenching Teeth
☐	☐	Catch Food Between Teeth	☐	☐	Uncomfortable or Uneven When I Bite My Teeth Together
☐	☐	Dry Mouth or Constantly Thirsty	☐	☐	Clicking or Popping of Jaw
☐	☐	Smoke or Use Chewing Tobacco	☐	☐	Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following?

YES	NO		YES	NO	
☐	☐	Dentures or Partials	☐	☐	Veneers
☐	☐	Braces or Clear Braces	☐	☐	Jaw Surgery
☐	☐	Periodontal Disease or Gum Treatments	☐	☐	Root Canals
☐	☐	Fixed Bridge	☐	☐	Sleep Apnea
☐	☐	Dental Implants	☐	☐	C-PAP Machine or Oral Sleep Appliance
☐	☐	Crowns	☐	☐	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

☐ Make My Teeth Whiter	☐ Repair Chipped Teeth
☐ Make My Teeth Straighter	☐ Replace Missing Teeth
☐ Close Spaces or Gaps That Bother Me	☐ Replace Old Crowns That Look Dark or Don't Match
☐ Replace Dark Metal Fillings With Tooth Colored Fillings	☐ Have a Smile Makeover
☐ Fix My Teeth So I'm Not Embarrassed When I Smile	☐ Stop My Jaw From Hurting or Clicking

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

Have you ever whitened your teeth? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

What is the most important thing to you about your dental visit today: _____

Why did you leave your previous dentist? _____

Montz and Maher Dental Group

Family, Cosmetic, Sedation and Implant Dentistry

Medical Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Address | Email | Phone

Please check Yes or No for those that apply to you.

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Kidney Disease	☐	☐	Seizures
☐	☐	Arthritis	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Stomach Problems
☐	☐	Artificial Heart Valve	☐	☐	Fainting	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Asthma	☐	☐	Heart Conditions	☐	☐	Nervousness / Depression	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Heart Lesions	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Bruise Easily	☐	☐	Heart Murmur	☐	☐	Periodontal Disease	☐	☐	Venereal Disease
☐	☐	Cancer	☐	☐	Heart Surgery	☐	☐	Radiation (Head / Neck)	***Women Only***		
☐	☐	Chemotherapy	☐	☐	Hepatitis: A B C	☐	☐	Respiratory Problems	☐	☐	*Birth Control*
☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐	*Nursing*
☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Rheumatism	☐	☐	*Pregnant*:
			☐	☐	Jaundice	☐	☐	Scarlet Fever	*Delivery Date*: _____		

Do you have any of the following drug allergies?

YES	NO		YES	NO		YES	NO		
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Percodan	Please list other allergies.
☐	☐	Codeine	☐	☐	Anesthetic	☐	☐	Penicillin	_____
☐	☐	Darvon	☐	☐	Nitrous Oxide	☐	☐	Antibiotics	_____
☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐	Other Allergies	_____

Please check any of the following drugs you have used at any time:

YES	NO		YES	NO		YES	NO	
☐	☐	Fosamax	☐	☐	Zometa	☐	☐	Boniva
☐	☐	Aredia	☐	☐	Skelid	☐	☐	Bisphosphonates

List ALL medications you currently take. (Prescription & Over The Counter. Attach List if Needed)

_____ _____ _____ _____

Using The Epworth Sleepiness Scale of 0 – 3 How likely are you to doze off or fall asleep in the following situations?
No chance of dozing = 0 Slight chance of dozing = 1 Moderate chance of dozing = 2 High chance of dozing = 3

__ Sitting and Reading
__ Watching TV
__ Sitting inactive in a public place, ie... theater or a meeting
__ As a passenger in a car for an hour without a break
__ Lying down to rest in the afternoon if conditions permit
__ Sitting and talking to someone
__ Sitting quietly after lunch without alcohol
__ In a car, while stopped for a few minutes in traffic
__ **TOTAL SCORE**

If under physicians care please explain?_____ Physician's Name: _____

_____ Physician's Phone: _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify PRACTICE NAME HERE of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold PRACTICE NAME HERE or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____ Dentist Signature: _____

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Family, Cosmetic, Sedation and Implant Dentistry

Office Policy Information

(Please Print)

- I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care, to third party payers and or health practitioners.
- I understand I am financially responsible for payments in full on all accounts I understand that payment is due at the time of service, unless other arrangements are made in writing.
- I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I authorize and hereby request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me
- I understand that my dental insurance carrier or payer of my dental benefits any pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

- I understand that any outstanding patient accounts past due 90 days will incur a $30 late fee and will be subject to an additional monthly billing late fee of $30 for any unpaid balance. I understand that a fee of $30 will be charged for any insufficient funds-returned checks. I understand that any more than two occurrences of a returned check will cause this office to accept only cash or credit for any future payment on my account.
- I understand that any cancellation or no show/failed appointment within 24 hours of my appointment will be subject to a $50 appointment cancellation fee to cover the expenses normally incurred for my reserved time.

- I understand that any repeated instances and/or circumstances involving failed appointment, cancellations, failure to schedule appointment for recommended treatment, failure to accept recommended treatment for oral health, and/or nonpayment in full o my account balance may result in termination of dental patient services provided by this office.

- I acknowledge and accept the terms of this office policy as described and I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in party by my dental care payer.

Patient Name: _____

Last First MI Preferred Name

Patient Signature:_____

Guardian Signature:_____ Relationship to Patient_____

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured 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 / 2000, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. 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 operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

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

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. **If you chose to have your health information emailed to you, please note that it will be unencrypted and may be unprotected.** We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your 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. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

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 if 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.

Our Privacy Official: Nathalie Dunwody
Telephone: 281-485-4829 **Fax:** 281-485-3225
Address: 2443 S. Galveston Ave, Pearland, TX 77581
E-mail: office@mmdentalgroup.com

MONTZ and MAHER DENTAL GROUP

* You May Refuse to Sign This Acknowledgment*

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

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

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)

Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling the office at 281-485-4829.

Email Address (PLEASE PRINT CLEARLY):

_____@_____

Patient Signature:_____

Date:_____

Authorization Form for Use or Disclosure of Patient Information

Patient Name:_____ Patient Date of Birth:_____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Specific description of the patient information to be used or disclosed (please select one):

- ☐ My complete health record
- ☐ Other (please specify): _____

I authorize Montz & Maher Dental Group to use and disclose my protected health information to the following person(s):

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Please acknowledge the following by initialing:

____ I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at **MONTZ & MAHER DENTAL GROUP**. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

____ I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

____ I understand that this authorization will be in effect indefinitely or until I rescind it.

Signature: _____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

*A copy of this authorization form is available at anytime at your request.