Submit Form

Print Form

Tel. 940-580-3389 Fax. 940-580-3394
1320 N. Grand Ave., Unit B
Gainesville, TX 76240

Today's Date
MM / DD / YYYY

Patient Information

First Name | Middle | Last Name

Date of Birth (MM / DD / YYYY) | Social Security # (- -) | Driver's License # | Gender ☐ Male ☐ Female | Marital Status

Street Address | Apt # | City | State | Zip

Cell Phone ( ) - - | Home Phone ( ) - - | Work Phone ( ) - -

Email Address

Whom may we thank for referring you?

Guardian Information

First Name | Middle | Last Name

Street Address | Apt # | City | State | Zip

Relationship to Patient | Employer | Work Phone ( ) - -

Home Phone ( ) - - | Email Address

Insurance

Insurance Company | Group # | Local #

Insurance Company Address

Policy Holder's Name | Social Security # (- -) | Date of Birth (MM / DD / YYYY)

Policy Holder's Employer | Occupation

RED RIVER FAMILY DENTAL
Tel. 940-580-3389 Fax. 940-580-3394
1320 N. Grand Ave., Unit B
Gainesville, TX 76240

Dental History

Why have you come to the dentist today?

	YES	NO
• Are you currently in pain?	☐	☐
• Are your teeth sensitive to hot or cold?	☐	☐
• Have you ever had a serious/difficult problem associated with dental work?	☐	☐
• Do you now or have you ever experienced pain in your jaw joints (TMJ/TMD)?	☐	☐
• Do your gums ever bleed?	☐	☐
• Have you ever had periodontal disease?	☐	☐
• Do you like your smile?	☐	☐

Medical History

Please check any of the follow which you have had or presently have:

- ☐ Anemia/Radiation Treatment
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Arthritis
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Difficulty breathing
- ☐ Drug/Alcohol abuse
- ☐ Emphysema
- ☐ Epilepsy/Seizures/Fainting Spells
- ☐ Fever blisters
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Heart surgery/pacemaker
- ☐ Hemophilia / Abnormal bleeding
- ☐ Hepatitis
- ☐ High/Low blood pressure
- ☐ HIV Positive/Aids
- ☐ Kidney problems
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Severe/Frequent headaches
- ☐ Sinus problems
- ☐ Ulcer/Colitis
- ☐ Venereal disease
- ☐ Hospitalized in the past year

If yes, explain:

Are you pregnant or think you might be pregnant? YES ☐ NO ☐

Please list any serious medical conditions you may have had:

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Penicillin ☐ Tetracycline ☐ Dental Anethetics ☐ Latex
☐ Other: _____

Emergency Contact | Phone ( ) - | Relationship

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment.

Payment is due in full at the time of treatment unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment or services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

Signature | Date MM / DD / YYYY

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Confidential Information Agreement

Please list the family members or other persons, if any, with whom we may discuss your dental treatment and/or your diagnosis:

Name | Phone

Name | Phone

Name | Phone

Please list the family members or other persons, if any, with whom we may discuss your dental treatment

ONLY IN AN EMERGENCY:

☐ Same as above ☐ No one ☐ The following:

Name | Phone

Name | Phone

Name | Phone

Please print the telephone number, if any, where you want to receive calls about appointments, billing and insurance inquiries, or dental healthcare questions.

Phone

May confidential messages be left on the answering machine or voice-mail number given above? ☐ YES ☐ NO

If you would rather we contact you via text message, please enter the cell phone number here:

Cell Number

If you do not have an answering machine or voice-mail, may a confidential message be left with a secretary or personal assistant? ☐ YES ☐ NO

I understand that this agreement remains in effect until revoked by me in writing. If I revoke my consent, such revocation will not affect any actions that Dr. Kevin Stewart or any RRFD Dentist took before receiving my revocation. I also understand and consent that the RRFD group of dentists share proceeds as part of their arrangement in bringing me excellent dental care.

Print Name

Signature

Date MM / DD / YYYY

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Notice of Privacy Practices

Effective November 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information ("IIHI") used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. HIPAA gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your IIHI information and how we may disclose your IIHI information. The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. We may use and disclose your medical records only for each of the following purposes:

1. Treatment, Payment, and Healthcare Operations

   Treatment means providing, coordinating or managing healthcare related services by one or more healthcare providers. An example of this would include teeth cleaning services.

   Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

   Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, and cost management analysis and customer service. An example would be an internal quality assessment review.

2. Pursuant to an individual's written authorization that meets HIPAA's criteria (i.e. specifying who is to receive the IIHI).
3. As required for compliance with the HIPAA Administrative Simplification Rules.

We also may create and distribute re-identified health information by removing all references to individually identifiable information. Further, we may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. The following categories describe the unique scenarios under which we may use or disclose your IIHI:

Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purposes of:

maintaining vital records, such as births and deaths
reporting child abuse or neglect
preventing or controlling disease, injury, or disability
notifying a person regarding potential exposure to a communicable disease
notifying a person regarding a potential risk for spreading or contracting a disease or condition
reporting reactions to drugs or problems with products or devices
notifying individuals if a product or device they may be using has been recalled
notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
Concerning a death we believe has resulted from criminal conduct
Regarding criminal conduct at our office
To identify/locate a suspect, material witness, fugitive, or missing person
In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator.)

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Individual Rights. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer. [The privacy office is Vicki Clark and he or she may be reached at 972-222-8700.]

1. The right to request restrictions on certain uses and disclosures of health information. Please note we are not required to agree with your request. For example, you may designate family members, relatives, close personal friends or any other person identified by you to receive disclosures and/or specify persons who will not receive any health information.

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2. The right to reasonably request to receive confidential communications of protected health information from us in a particular manner or at a specified location. For example, you may request that we contact you only at home and not work, for appointment reminders or any other communication.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information that you believe is incorrect or incomplete, by following specific procedures set forth in HIPAA. We may deny your request in certain situations, e.g., the information is accurate or was provided by a third party, such as a laboratory.
5. The right to receive an accounting of certain disclosures of protected health information upon written request and by meeting the conditions set forth in HIAA.
6. The right to obtain a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Vicki Clark at 972-222-8700. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Your private health information cannot be sold. You have the right to opt out of being contacted about fundraising. You have the right to restrict our practice from disclosing your out of pocket expenses. You have the right to limit our practice from disclosing genetic information. We are required by law to maintain the privacy of your protected health information, to provide you 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.

For more info about HIPAA:

Office of Civil Rights

200 Independence Ave. S.W.
Washington, D.C. 20201
202-619-0257

Red River Family Dental

1320 N. Grand Ave, Unit B
Gainesville, TX 76240

Privacy Officer

Vicki Clark
972-222-8700

Signature

Date

MM / DD / YYYY