

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.		FAX		
CELL		EMAIL		
BIRTH DATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL		GRADE		
SOCIAL SECURITY NO.				



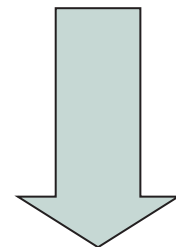
DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP



Welcome! So that we may provide you with the best possible care, please fully complete this dental history form. All information is completely confidential.

PATIENT NAME

MEDICAL ALERT

What is the reason for your visit today? _____

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric brush, waterpik®, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodonal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

Do you:

Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No

Have you experienced:

Clenching or grinding your teeth while awake or asleep?	Yes	No
Tired jaws, especially in the morning?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain? (join, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life?	Yes	No
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Do you feel nervous about having dental treatment?

If so, what is your biggest concern? _____

Have you ever had and upsetting dental experience?	Yes	No
--	-----	----

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

PATIENT NAME
MEDICAL ALERT

Welcome! So that we may provide you with the best possible care, please fully complete this medical history form. All information is completely confidential.







1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
2. **Are you taking any medication, drugs, or pills now, including regular dosages of aspirin?** Yes No
 If yes, please list: _____
3. Are you taking any supplements? Yes No
4. **Are you aware of having an allergic (or adverse) reaction to any medication or food?** Yes No
 If yes, please list: _____
5. **Have you ever smoked or used tobacco products?** **Yes** **No** **Packs/Day** _____ **How Long** _____
6. Have you ever been advised to take Antibiotics before dental treatment? Yes No
7. Have you ever taken Bisphosphonate medication for Osteoporosis (Fosamax, Zometa, Boniva, etc.) Yes No
8. Have you ever taken prescription medications for weight loss (diet pills, Fen-Phen, Redux, etc.)? Yes No
9. Do you have a history of snoring or sleep apnea (CPAP, BiPAP)? Yes No
10. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack) Yes No	Ulcers Yes No	Hepatitis A (infectious) B (serum) Yes No
Chest Pain Yes No	Diabetes Yes No	Venereal Disease Yes No
Congenital Heart Disease Yes No	Thyroid Problems Yes No	A.I.D.S. Yes No
Heart Murmur Yes No	Glaucoma Yes No	H.I.V. Positive Yes No
High Blood Pressure Yes No	Contact Lenses Yes No	Cold Sores/Fever Blisters Yes No
Mitral Valve Prolapse Yes No	Emphysema Yes No	Blood Transfusion Yes No
Artificial Heart Valve Yes No	Chronic Cough Yes No	Hemophilia Yes No
Heart Pacemaker Yes No	Tuberculosis Yes No	Sickle Cell Disease Yes No
Rheumatic Fever Yes No	Asthma Yes No	Bruise Easily Yes No
Arthritis/Rheumatism Yes No	Hay Fever Yes No	Liver Disease Yes No
Cortisone Medicine Yes No	Latex Sensitivity Yes No	Yellow Jaundice Yes No
Swollen Ankles Yes No	Allergies or Hives Yes No	Neurological Disorders Yes No
Stroke Yes No	Sinus Trouble Yes No	Epilepsy or Seizures Yes No
Diet (Special/Restricted) Yes No	Radiation Therapy Yes No	Fainting or Dizzy Spells Yes No
Artificial Joints (hip, knee, etc.) Yes No	Chemotherapy Yes No	Nervous/Anxious Yes No
Kidney Trouble Yes No	Tumors Yes No	Psychiatric/Psychological Care Yes No
10. Have you lost or gained more than 10 pounds in the past year? Yes No
11. Do you have or have you had any disease, condition, or problem not listed? Yes No
12. If yes, please list: _____

Women. Are you: **Pregnat?** Yes, _____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

HISTORY & REVIEW

CONSENT TO TREATMENT

-  I hereby authorize the doctor or designated staff to conduct an exam, and take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
-  Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me, and employ such assistance as required to provide proper care.
-  I agree to the appropriate use of anesthetics, sedatives and other medication deemed necessary. I fully understand the use of these agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
-  I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations. I give my permission to the doctors to make any changes or additions necessary.
-  I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.
-  I agree to be responsible for the entire costs of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If payments are not received by the agreed upon dates, I understand that a late charge may be added to my account, and that other measures may be taken in order to collect full payment for services rendered.

Please sign and date the corresponding signature page to acknowledge that I have read and understood the above form, have asked the necessary questions, and have had them answered to my satisfaction. I consent to receive treatment at this practice according to these terms.



NOTICE OF PRIVACY PRACTICE

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.
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. This Notice takes effect March 1, 2010, 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 make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. 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 to 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 qualifications 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 any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us 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 your 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.

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 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 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, text 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. You may also request access by sending us a letter to the address at the end of this Notice.)

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 March 1, 2010. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, costbased 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 an 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 Web site 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: Jennifer McDonald
Telephone: 830-693-0748
Fax: 866-868-0748
Email: info@stanleydental.net
Address: 800 Esperanza Ave.
Marble Falls, TX 78657



ACKNOWLEDGEMENT AND SIGNATURE PAGE

By signing below, I hereby acknowledge that I have: **1)** filled out my patient registration form with the most accurate and up to date information, **2)** filled out my dental and medical history forms to the best of my knowledge with the most current information and **3)** Have read the consent to treatment form and acknowledge that I fully understand and agree with the terms that were listed.

PRINT NAME

SIGNATURE

RELATIONSHIP TO PATIENT (IF NECESSARY)

DATE



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

PRINT NAME

SIGNATURE

RELATIONSHIP TO PATIENT (IF NECESSARY)

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) _____

STANLEY DENTAL REPRESENTATIVE