ROSE DENTAL GROUP

PATIENT INFORMATION

Date _____

PATIENT INFORMATION

Name _____

Address _____

City/State/Zip _____

Employer _____

Hm. Phone #_____

Cell Phone # _____

Email Address _____

Sex: M ☐ F ☐ Drivers Lic. # _____

Social Security #_____DOB_____

Marital Status: Single ☐ Married ☐

POLICY HOLDER INFORMATION

Name _____

Address_____

City/State/Zip _____

Phone # _____

Employer _____

Social Security # _____DOB_____

Dental Insurance _____Group # _____

RESPONSIBLE PARTY INFORMATION

Name _____

Address _____

City/State/Zip _____

Employer _____

Hm. Phone_____

Other Phone _____

Email Address _____

Sex: M ☐ F ☐ Drivers Lic. # _____

Social Security #_____DOB_____

Person to contact outside of immediate family in case of emergency:

Name _____Phone # _____ Alternative #_____

ACCESS TO PROTECTED HEALTH INFORMATION

Name: _____ Relationship: Spouse ☐ Child ☐ Other ☐

Name: _____ Relationship: Spouse ☐ Child ☐ Other ☐

HOW DID YOU HEAR ABOUT US?

☐Social Media/Facebook ☐Advertisement/Events: _____ ☐ Rose Dental Website

☐Yelp/Other Review Site: _____ ☐Google ☐1-800 Dentist ☐Drive-by/Walk-in

☐Insurance ☐Rose Dental Referral: _____ ☐Other:_____

Thank you for choosing us. All information you give us is strictly confidential and will not be released to anyone without written consent.

_____ _____

Signature (Patient, Parent, or Guardian) Date

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DATE: _____
Patient Name: _____
DOB: _____

ROSE DENTAL GROUP

Medical History

Do you currently have or have a history of any of the medical conditions below and check all that apply.

- ☐ **UNFAVORABLE REACTION** to dental anesthetic
- ☐ **LATEX** Allergy
- ☐ Rheumatoid Arthritis
- ☐ Total Joint Replacement
- ☐ Heart Murmur
- ☐ Non-repaired Heart Valve Defect
- ☐ Cancer within last 12 months
- ☐ Human Papillomavirus (HPV)
- ☐ Cardiac Pacemaker / Defibrillator
- ☐ Pregnant/Nursing Mother
- ☐ Hepatitis **A** (Infectious)
- ☐ Anemia
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Osteoporosis
- ☐ Glaucoma
- ☐ COPD
- ☐ Electronic Cigarettes
- ☐ Low Blood Pressure
- ☐ Blood Transfusion
- ☐ Hepatitis **B** (Serum)
- ☐ **Antibiotic PRE-MED** before dental treatment
- ☐ AIDS or HIV
- ☐ Seizure Disorder
- ☐ Diabetes Type 2
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoke Tobacco
- ☐ Fainting Tendency
- ☐ Excessive Bleeding
- ☐ Hepatitis **C**
- ☐ Recent Surgery
- ☐ Diabetes Type 1
- ☐ Thyroid Disorder
- ☐ Breathing Difficulty
- ☐ High Blood Pressure (BP)
- ☐ BP CONTROLLED by MEDs
- ☐ Smokeless Tobacco
- ☐ Dizziness upon standing
- ☐ Tuberculosis

Do you require a Sign Language Interpreter to communicate? ☐ No ☐ Yes

Are you under the care of a Pain Management Doctor? ☐ No ☐ Yes

If Yes - Doctor's Name: _____ Phone: _____

List all other pertinent medical diagnoses or conditions: _____

_____

_____

Physician's Name: _____ Phone: _____

Date of Last Physical Exam: _____

Preferred Pharmacy: _____ Phone: _____

List all medication allergies: _____

_____

_____

List current medications: prescription & over-the-counter: _____

_____

_____

NOTE: If you have a **lengthy medication list**, please provide a list that we may scan into your dental record.

All information is strictly confidential and will not be released without written consent.
Thank you for allowing Rose Dental to be your dental healthcare provider.

Patient's Signature: _____ Date: _____

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Revised 8/2018

Patient Name: _____ **Date:** _____

ROSE DENTAL GROUP

Smile Information / Dental Information

Smile Information	YES
Would you like to improve the way your teeth & smile look?	☐
Would you like to have a whiter, brighter, more youthful smile?	☐
Would you like to have straighter teeth?	☐
Do you have spaces between your teeth that you would like closed?	☐
Would you like to know more about straightening your teeth without wearing braces? [Invisalign Alignment]	☐
Would you like to improve the shape of your teeth?	☐
Would you like your teeth to be longer?	☐
Do you have missing teeth that you would like to replace?	☐
Do you have old silver fillings that you would like to replace with tooth colored fillings?	☐

Dental Information		
Date of last:Dental Exam:	**Date of last:Dental X-rays:**	**Date of last: Dental Cleaning**:

	YES
Are you currently experiencing a toothache or any pain in your head or neck? If YES explain:	☐
Have you had any changes in your bite? If YES explain:	☐
Do you have difficulty chewing: If YES explain:	☐
Do your teeth seem to be shifting: If YES explain:	☐

Do You Have A History		YES
Do you have a history of Gum Disease? If YES, provide the following:		☐
Name of Dentist that treated your Gum Disease		
Date of Surgery or Deep Cleaning (Scaling/Root Planing)		
Date of last Periodontal Therapy visit.		
Clinching or Grinding (Bruxism) Teeth?		☐
Have you ever worn a mouth guard/night guard?		☐
Do you have difficulty opening or closing your mouth?		☐
Clicking / Popping OR Pain in the Jaw Joint (TMJ)? If YES explain:		☐
Do you have frequent headaches?		☐
Do you breathe mainly through your nose, mouth or both?	Nose?	☐
	Mouth ?	☐
	Both?	☐
Do you snore?		☐
Does anyone in your household snore?		☐
Do you feel like you sleep well at night?		☐
Are you currently being treated for **sleep apnea**?		☐
Bad Breath (Halitosis)?		☐
Abscesses?		☐
Tooth Sensitivity?		☐
Mouth Sores (Ulcers)?		☐
Cold Sores / Fever Blisters?		☐
Any other dental condition or experience we should be aware of? If YES explain:		☐

All information is strictly confidential and will not be released without written consent.
Thank you for allowing Rose Dental to be your dental healthcare provider.

PATIENT SIGNATURE: _____ **DATE:** _____

Revised 5/18/2017

PATIENT NAME: _____

ROSE DENTAL GROUP

Oral Hygiene Care & Examination Consent

Rose Dental Standard of Care

Dental Prophylaxis (Cleaning):

A "regular" adult or child dental cleaning is performed every 3-6 months in a mouth with healthy supporting periodontal tissue with no evidence of periodontal disease. During the dental cleaning scaling is done to remove any calculus (tartar) deposits and the teeth are polished to remove all plaque and stain from the tooth surface.

Caries Risk Assessment:

Each patient's caries risk will be assessed at each dental cleaning visit. Your dentist and dental hygienist will make treatment recommendations based on your individual risk factors. Recommendations may include fluoride varnish or other therapeutic agent.

Periodontal Maintenance (After Periodontal Therapy):

Periodontal Maintenance Therapy (PMV) refers to the maintenance of the dental bone and is the standard of care following active periodontal therapy either periodontal surgery or scaling and root planing. The frequency of PMV visits will be every 3 months for the first 18 months following active periodontal therapy. After this 18-month period, maintenance visits will be scheduled every 3-4 months as determined by your dentist and hygienist based on your individual needs. Patients may notice mild or moderate sensitivity of the exposed root surfaces; sensitivity toothpaste or a fluoride varnish to reduce this sensitivity may be recommended.

Oral Examinations:

Rose Dental Standard of Care for diagnosing dental disease/infection includes dental examinations two (2) times per year: An ***Annual*** Examination with X-rays and a ***Semi-Annual*** Oral Examination without x-rays.

Enhanced Oral Cancer Screening:

Rose Dental Standard of Care for the diagnosis of oral cancer consists of a **Standard *Visual*** & an **Enhanced** Oral Cancer Screening (OCS). The Standard Visual OCS is part of the routine dental examination. Patients 18 years and older will be offered the Enhanced OCS one time per year. During the Enhanced OCS your dentist/hygienist will use safe state-of-the-art, technology which utilizes fluorescence to scan the soft tissues of the mouth and throat to pinpoint areas that are not visible to the naked eye.

Periodontal Evaluation:

Rose Dental Standard of Care for all adult patients (18 years and older): This diagnostic full mouth probing (FMP) maps the periodontal soft tissue attachment between the tooth and supporting hard/ soft tissue along with the signs and symptoms of periodontal disease which include: tissue bleeding, recession, tooth mobility, tooth root exposure, and pus are noted. FMP are performed at each hygiene examination. Note, in a healthy mouth this is a painless procedure.

X-rays:

X-rays are a vital diagnostic tool that aids your dentist in detecting dental disease/infection not detectable during the visual examination. Your dentist will evaluate each patient and prescribing the x-rays deemed necessary to make a comprehensive diagnosis. Rose Dental supports the recommendation of a full mouth x-ray series and a panoramic x-ray every 3 years, as determined by your dentist. Note: Rose Dental uses protective torso and thyroid lead shields and low emission digital radiography for patient safety.

I understand and consent to the above standard of care.

As with any procedure, you are responsible for understanding your plan and any exclusion and/or frequency limitations, how these relate to your dental procedures and services are not covered by your insurance.

NOTE: Minor patient (under 18 yrs. of age) must be accompanied by an adult OR must have a completed Rose Dental Parent/Guardian Consent Form For Unaccompanied Minor Patients signed by the parent/guardian on file giving consent to treat the minor.

Patient/Guardian Signature:_____ **Date:**_____

ROSE DENTAL GROUP

PATIENT POLICIES

Thank you for choosing our office for your dental care. We are committed to providing the highest quality dental care through the use of state-of-the-art technology, equipment and training. We will always recommend and provide you with the best clinical procedures without regard to the limitations imposed by your insurance coverage. Our practice is "health centered" rather than "insurance centered". We hope that by providing you with our policies in advance we can prevent misunderstanding and frustration. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

Full payment is due at time of service. We accept cash, checks and Visa/Master Card/Discover/American Express. We also offer dental financing as an extended payment option. Ask our staff for details. =Please understand that payment of your bill is considered a part of your treatment.

INSURANCE

Please be aware that each insurance company and each individual insurance plan is unique. As a courtesy, we obtain basic benefit eligibility from your insurance so that we can offer you an estimate of your benefits. The estimated percentage not covered, including any deductible, is to be paid at the time of service.

You are fully responsible for understanding *your* plan and any exclusions, alternative benefit, frequency limitations, missing tooth clauses etc. and how these relate to your dental procedures.

At any time, if you have questions regarding your plan as it relates to your treatment, we will be happy to try to answer to the best of our knowledge. *However, it is your responsibility to verify plan benefit coverage with your insurance company.*

If your insurance plan does not cover procedures as estimated for any reason, the portion not covered is your responsibility at 60 days of non-payment from the insurance company from date of service. In an event that your insurance should pay us after that time, you will be reimbursed.

We will file your insurance as a courtesy; however, we need the following information to offer you this service:

Name of Insurance	Group Number
Employer of Policy Holder	Patient DOB and/or Policy Holder DOB
Member Number and/or Social Security Number	1-800 # for Insurance Company

While we make a good faith attempt to verify coverage we are not able to guarantee that the information given to us by your insurance is correct. We make no claim to know what services your insurance covers. Please keep in mind your contract is between you and the insurance company. Your involvement in the process of providing us with proper information, and you being proactive in knowing your plan, will help us maximize your benefits to their full potential. We encourage you to refer to your benefits manual or insurance company's customer service if you have any questions about covered services. You are responsible for payment regardless of your insurance company's determination of usual and customary rates, if our office does not participate in your plan.

Regarding PPO insurance plans, it is your responsibility to be sure we are a participating (in network) provider on your dental plan.

Regarding DMO and discount insurance plans, which are reduced fees, there is no reimbursement for services from your insurance company. The reduced fee and presentation of your insurance card or verification of coverage is required at the time of treatment. If we are unable to verify the plan or if there is a denial of coverage at any time, you will be responsible for the full UCR fee.

MINOR PATIENTS

(Under 18 years of age unless a demonstrated exception applies under the Texas Family Code, such as active duty with the United States armed services):

- **Initial New Patient appointment**: Minor must be accompanied by a legal guardian.
- **Subsequent appointments for Routine Cleaning/Examination & Restorative appointments:**
  - Must be accompanied by a legal guardian
    OR
  - Must have a completed *Rose Dental Parent/Guardian Consent Form for Unaccompanied Minors* form
    OR
  - Must bring a written note giving consent to treatment of unaccompanied minor signed by the parent/legal guardian.
- If the legal guardian is NOT present at subsequent visits, he or she must be available by phone in the event of an emergency to approve any changes in treatment, or for any other reason that may arise.

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- For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by legal guardian.
- The legal guardian is responsible for full payment of services at the time of treatment. If the recommended plan of treatment changes, approval is required from the legal guardian.
- The legal guardian is required to notify our office of any changes in the minor's medical history prior to treatment.
- Prior to any restorative appointment, the legal guardian must review and sign the patient's *Treatment Plan of Care* and the *Rose Dental Treatment Consent*.

DIVORCE DECREES

This office is NOT a party to your divorce decree. The legal guardian who accompanies the minor at the appointment is responsible for payment.

INTEREST, REBILLING, COLLECTION FEES AND RETURNED CHECKS

Interest in the amount of the 18% APR will be charged to any remaining balance after 60 days. If your account is turned over to a collection agency, in addition to interest, you will be charged a collection fee. Our bank charges us for insufficient funds of a deposited check, therefore you will be charged $30.00 for returned checks by a third party.

MISSED APPOINTMENTS

We request a 48-hour notice for all cancelled or rescheduled appointments. If you miss 3 appointments without adequate cancellation time, we reserve the right to have future appointments prepaid or you may be dismissed as a patient from the practice. If you arrive more than 15 minutes late for your scheduled appointment, you may be asked to reschedule your appointment to another time and/or day. Deposits made for appointments with our Specialists are non-refundable.

CONSENT FOR WEB BASED AND/OR TEXT MESSAGE COMMUNICATION

Rose Dental Group provides our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online
- Office information/news/updates
- Billing Information
- Future discounts/offers

Rose Dental Group always provides the ability for our patients to opt-out of our online program through an immediate opt-out mechanism contained in each email or text message delivered. We will not use your information for any other purpose than in-office communication.

CONSENT FOR ALTERNATIVE MEANS OF COMMUNICATION

Rose Dental Group may use alternative means of communication (fax, email, voice mail/voice messages, electronic transmission) to communicate Protected Health Information to any of the following: an approved covered entity (such as, a dental specialist, insurance company etc.), a legal guardian, or the patient.

**** It is your legal option to not sign this acknowledgement, however our policy states that if we do not have this signed acknowledgement from you, we will not be able to provide you with our services.****

***If you would like a copy of this page please notify the front desk.**

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ROSE DENTAL GROUP

Notice of Privacy Practices: Your Information & Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights. You have the right to: Get a copy of your paper or electronic medical record; correct your paper or electronic medical record; request confidential communication; ask us to limit the information we share; get a list of those with whom we have shared your information; get a copy of this privacy notice; choose someone to act for you; file a complaint if you believe your privacy rights have been violated.

Your Choices. You have some choices in the way that we use and share information as we: Tell family and friends about your condition; provide disaster relief; market our services.

Our Uses and Disclosures. We may use and share your information as we: Treat you; run our organization; bill for your services; help with public health and safety issues; do research; comply with the law; respond to organ and tissue donation requests; work with a medical examiner or funeral director; address workers' compensation, law enforcement, and other government requests; respond to lawsuits and legal actions.

Your Rights. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Your Choices. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care; share information in a disaster relief situation; include your information in a hospital directory. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* In these cases we never share your information unless you give us written permission: Marketing purposes; sale of your information. In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures. How do we typically use or share your health information? We typically use or share your health information in the following ways: **1. Treat you.** We can use your health information and share it with other professionals who are treating you. **2. Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. **3. Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. **1. Help with public health and safety issues.** We can share health information about you for certain situations such as: Preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety. **2. Do research**. We can use or share your information for health research. **3. Comply with the law**. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with the federal privacy law. 4. **Respond to organ and tissue donation requests**. We can share health information about you with organ procurement organizations. **5. Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies. **6. Address workers' compensation, law enforcement, and other government requests**. We can use or share health information about you: For workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; for special government functions such as military, national security, and presidential protective services. **7. Respond to lawsuits and legal actions**. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information, see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Rose Dental Group Privacy Contacts:

Practice Manager: angus@rosedental.net (512) 795-9643
Practice Manager: roundrock@rosedental.net (512) 310-9374
Practice Manager: williamcannon@rosedental.net (512) 288-4777
Practice Manager: parmer@rosedental.net (512) 251-6125

This notice tracks the model Notice of Privacy Practices developed by the U.S. Department of Health and Human Services pursuant to the Omnibus Rule (2013) modifying HIPAA (the Health Insurance Portability and Accountability Act of 1996).

Effective Date of this Notice: 10/29/2014

Patient Name: _____ Date: _____

ROSE DENTAL GROUP

ACKNOWLEDGEMENT OF RECEIPT / REVIEW OF PATIENT POLICIES & NOTICE OF PRIVACY PRACTICES

I, _____ have received/reviewed a copy of this office's Patient Policies & Notice of Privacy Practices.

I have read, understand and agree to abide by the terms stipulated in the above Patient Policies.

_____ **Date:** _____

Signature of Patient or Legal Guardian if a minor

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