Health History (blue or black ink only)

Grey areas for office use only

Electronic HH entered by_____
Electronic Record entered by _____

Name _____ Nickname _____ Email _____
Last First Middle

Address _____ City _____ State _____ Zip _____
P.O. Box or Mailing Address

Home Phone (_____)_____ Business Phone (_____)_____ Cellular Phone (_____)_____

Sex ☐ M ☐ F Date of Birth _____/_____/_____ Drivers License # _____ State _____ SS# _____

Occupation _____ Whom may we thank for referring you to our practice? _____

If you are completing this form for another person, what is your relationship to that person? _____ Your Name _____ Relationship to Patient

(If you are completing this for another person, please record your Business Phone, Drivers License # and Occupation)

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

What prompted you to seek dental care at this time? _____

Date of your last dental exam _____ Date and type of last dental xrays _____ Full Mouth_____Panorex_____Bitewings_____

Yes	No	
☐	☐	Are you dissatisfied with your teeth in any way?
☐	☐	Are you aware of clenching or grinding your teeth?
☐	☐	Do any of your fillings show when you smile?
☐	☐	If any of your silver fillings need replacement, would you prefer to have a more natural tooth-colored restoration instead?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?
☐	☐	Do you wear removable dental appliances?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Would you like to explore the possibilies of improving the appearance of your teeth or smile?

☐ ☐ Do you have any financial concerns related to dentistry? (Explain) _____

☐ ☐ Are you fearful of dentistry? Rate fear level (1-10)_____ Do you have a reason for the fear? (Explain) _____

Medical Information

A–Auto Trigger Medical Alert **M**–Manual Trigger Medical Alert
P–Premedicate for this condition

Medical Alert	Yes	No	
	☐	☐	Are you in good health?
	☐	☐	Has there been any change in your general health within the past year?
	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____ Date of last physical examination _____

Physician(s) _____
Name phone city/state
_____
Name phone city/state

M	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what was the illness or problem? _____
	☐	☐	Are you taking any medicine(s) including non-prescription medicine? **Medication** **Reason for medication** _____
A	☐	☐	Are you taking or being treated with , or have you taken or been treated with , any **IV or Oral Bisphosphonate drugs** such as : Reclast (IV/zoledronate), Fosamax (Oral/Alendronate), Boniva (Oral/Ibandronate), or Actonel (Oral/Residronate)?
M	☐	☐	Are you **alcohol** and/or **drug dependent**? If so, have you received treatment? ☐Yes ☐ No
	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? ☐Very ☐ Somewhat ☐Not interested

Height _____ft_____inches Weight _____lbs

		Medical Alert			Medical Alert
A	Anticoagulant	A	H	Hormones	M
BC	Birth Control	A	I	Inhaler (asthma)	A
BP	Blood pressure	A	O	Other meds	M
C	Cardio medication	A	O*	Other meds	A
CH	Cholesterol	M	S	Seizure meds	A
D	Diabetic	A	SA	Sinus/allergy	M
DA	Depression/Anxiety	M	T	Thyroid	M

Allergies

Are you allergic to or have you had a reaction to: (Please fill out both columns)

Medical Alert	Yes	No	
A	☐	☐	Aspirin
M	☐	☐	Barbituates/Sedatives
A	☐	☐	Codeine
A	☐	☐	Dental Anesthetics
A	☐	☐	Erythromycin
A	☐	☐	Jewelry _____
A	☐	☐	Latex

Medical Alert	Yes	No	
A	☐	☐	Metals _____
A	☐	☐	Penicillin
M	☐	☐	Sulfa Drugs
A	☐	☐	Tetracycline
M	☐	☐	Other antibiotic (specify) _____
M	☐	☐	Other specify _____

(Women Only)

Yes No

☐ ☐ Are you pregnant? How many weeks? _____ Due Date _____

☐ ☐ Are you nursing?

Enter in General Tab & Conditions Tab of MH and Put Details In Other Tab of MH

A–Auto Trigger Medical Alert **M**–Manual Trigger Medical Alert P—Dr. evaluate for Premedication type and dosage

Medical History

Have you experienced or do you currently have any of the following conditions? (Please fill out both columns)

Medical Alert	Yes	No	
M	☐	☐	Abnormal bleeding
A	☐	☐	AIDS or HIV infection
	☐	☐	Anemia
	☐	☐	Arthritis
A	☐	☐	Asthma
	☐	☐	Blood Transfusion if yes, date _____
M	☐	☐	Cancer/chemotherapy/ radiation treatment
	☐	☐	Cardiovascular disease, **If yes, specify below:**
A/P			○ **Artificial heart valves**
M/P			○ Congenital heart defects
M			○ Coronary insufficiency
A			○ **Damaged heart valves**
A			○ Heart attack/angina
M			○ Heart murmur
M			○ **H**igh **B**lood **P**ressure
M			○ **M**itral **V**alve **P**rolapse
A			○ Pacemaker
M			○ Rheumatic heart disease
M	☐	☐	Chest pain upon exertion
M	☐	☐	Chronic Pain

Medical Alert	Yes	No	
A	☐	☐	Immunosupression disease, drug or Radiation induced
	☐	☐	Diabetes, **if yes, specify**
A			○ Type I (insulin dependent)
			○ Type II
	☐	☐	Dry Mouth
M	☐	☐	Epilepsy/Seizures
M	☐	☐	Fainting spells
	☐	☐	Glaucoma
	☐	☐	Hemophilia
M	☐	☐	Hepatitis, jaundice,or liver disease _____
	☐	☐	Kidney problems
M	☐	☐	**L**ow **B**lood **P**ressure
	☐	☐	Mental health disorders **If yes, specify below:** _____ _____
M	☐	☐	Headaches, frequent migraines

Medical Alert	Yes	No	
	☐	☐	Swollen **glands** in neck - Persistent
	☐	☐	Respiratory problems **If yes, specify below:**
A			○ Emphysema
M			○ Shortness of breath
A	☐	☐	**STD** -Sexually Transmitted disease
	☐	☐	Sinus problems
	☐	☐	Sleep disorder
	☐	☐	**Ulcers in** the **mouth**
M	☐	☐	Stroke
A	☐	☐	Lupus
M	☐	☐	Thyroid problems
A	☐	☐	Tuberculosis
M	☐	☐	Ulcers
M	☐	☐	Do you have any other disease, condition, or problem that you think I should know about? Please explain:_____ _____ _____ _____ _____ _____

A/P

☐ ☐ Have you had an **artificial joint replacement** (hip, knee, elbow, finger, etc.)? If so, when was this operation done? _____

☐ ☐ Have you had any complications or difficulties with your prosthetic joint?

☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

If so, what antibiotic?_____ Dose_____

Name of physician or dentist _____ Phone (____)_____

Emergency Contact _____ Relationship _____ Phone (____)_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Crabtree, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient/Legal Guardian Date

Below for completion by dentist (items not addressed in medical alert columns)

Medical Alert A Also Put P in Patient User codes

Yes No

☐ ☐ Dental Appointment **Premed** instructions: Amoxicillin Cleocin Keflex ☐ per AHA Guidelines

OR: _____

Comments/Significant findings from oral interview not found on questionnaire:

_____

Dental management considerations:

_____

_____ _____

Signature of Dentist **Date**

Ronald K. Crabtree, D.D.S., P.A.
23056 Westheimer Parkway Katy, Texas 77494
Tel: (281) 347-1960

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent; but you are not required to do so. If you refuse to sign this consent form, we may decline to treat you or continue treating you.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Patient Name:	
Printed name of person consenting:	Relationship to patient:
Signature:	Date:

Ronald K. Crabtree, D.D.S. ,P.A.
23056 Westheimer Parkway, Texas 77494
Tel: (281) 347-1960

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's notice of privacy practices for and in behalf of:

Patient Name:_____

Printed name of person acknowledging receipt:	Relationship to patient:
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
- ❑ Patient is a minor child who came in for appointment without parent. Notice was mailed to parent with receipt requested.
- ❑ We failed to get acknowledgement when patient was in office and instead mailed privacy notice and receipt to the patient.
- ❑ Other (Please Specify)

_____

_____

Ronald K. Crabtree, D.D.S., P.A.
23056 Westheimer Parkway Katy, Texas 77494
Tel: (281) 347-1960

FINANCIAL AGREEMENT AND AUTHORIZATION

We are dedicated to helping you keep your smile healthy and beautiful for a lifetime. We know you depend on us to explain all dental procedures and associated fees clearly and professionally before we begin treatment. It is our policy to make definite financial arrangements with patients before any treatment begins. You can count on us to help in every way we possibly can to make the most exceptional dentistry affordable. We're pleased to offer different payment options including low or no interest payments. Our team is happy to assist you with choosing and qualifying for a payment option that best fits your needs. Regardless of the payment option arranged the following terms will apply:

1) Payment as arranged is due in full at each visit with cash, check, or credit card.
2) If you have insurance benefits, you assign them to us, and we accept assignment, we will manage your account as follows:
   i) No administrative fee will be assessed for filing insurance claims; we will provide this service as a courtesy.
   ii) You must provide us with accurate insurance billing information prior to your appointment or you will be responsible for payment in full. (*When possible, we prefer to receive insurance information in advance of your appointment so that we can avoid delays in estimating your benefits at the time of service.)*
   iii) We will research your benefits and estimate coverage based on our insurance expertise. We do not guarantee our benefit estimates to be correct and are not responsible for benefits that are not paid exactly as estimated.
   iv) If we cannot reasonably estimate secondary insurance coverage the office will accept assignment for only the primary insurance coverage. You must file your own secondary insurance coverage in this instance.
   v) You are responsible for paying deductibles and estimated co-payments when making appointments. You are also responsible for paying all charges not covered by your insurance plans, including all fees considered above your insurance policy's usual and customary fee schedule.
   vi) Information requests to you from the insurance company and/or our practice must be promptly responded to.
   vii) The office will submit a claim to an insurance company up to two times per appointment for the purpose of obtaining payment. Further insurance appeals are your responsibility.
   viii) You are responsible for insurance balances in full after 60 days, even if your insurance company has not paid; further insurance appeals beyond the 60-day period are your responsibility.
   ix) Insurance benefits are a contract between the patient and his/her employer. The coverage received depends upon the quality of the plan purchased by his/her employer, not our fees. You are financially responsible for all products and services provided. Any insurance benefit not paid as estimated is your responsibility.
   x) If your balance after insurance payment is under $5 it will be collected on your next visit to our practice. A statement for balances over $5 will be mailed to your account address and will be due within 30 days of billing.
3) If payments to your account result in a credit balance we will maintain the amount on your account to be used towards future services. If you prefer you may notify us that you would like a refund of the credit amount. (*To have a credit balance there can be no outstanding insurance claims on your account.*) If we believe the insurance company has paid claims to your account in error and we anticipate that they will request payment back, we will not issue the refund to you until such time as we believe they will no longer require a refund.
4) The practice cannot carry balances longer than 90 days. Patients will be informed that their accounts are delinquent so they can avoid collection action. A fee of $30 will be assessed for all accounts referred to an attorney and/or collection agency for payment.
5) A service charge of $25 for all returned checks will be assessed. If the balance due is not promptly resolved within 7 days of the returned check collection action will be initiated and the patient will lose check-writing privileges in our practice.
6) For minor patients of divorced parents, the parent who initially brings the child in for treatment is considered financially responsible to our practice regardless of the divorce decree. We cannot be caught in the middle of family financial disputes.
7) Where appropriate credit bureau reports may be obtained to manage your account.
8) We request 2 business days' notice for any change in your scheduled appointments. When you make an appointment we reserve a treatment room, appropriate staff, and equipment just for you. Canceling or missing appointments with short notice makes it impossible for us to offer your reserved slot to another patient. If insufficient notice is received you will be assessed a fee per appointment. The current fee is $45 per appointment.

AGREEMENT: I have read, understood, and accept the financial agreement outlined above. I understand that this agreement applies to all patients in my account. **AUTHORIZATION:** I authorize Crabtree Dental staff to submit claims for payment for services to my health care service plans, insurance companies, or other benefit programs on my behalf. I assign to Crabtree Dental insurance benefits otherwise payable to me. This financial agreement and authorization shall remain in effect as long as I receive dental services from Crabtree Dental. **AGREED TO AND AUTHORIZED BY:**

Printed name of account guarantor/insured	Patient Name
Signature of account guarantor/insured	Date:

Image Consent and Release

(Initial)_____I understand that in the course of my treatment, Dr. Crabtree and/or his team may take images of my face, jaws and teeth such as radiographs, photographs, video and digital pictures (hereinafter referred to as "images"). I understand that these images will be used as a record of my care and treatment, and may be used for educational purposes in lectures, and demonstrations by Dr. Crabtree and/or his team. I also understand that these images and any testimonials I may provide can be used by Crabtree Dental for professional marketing. The purpose of this marketing is to help other patients and prospective patients understand the benefits of services rendered by this office. Marketing may be in the form of print media, video, television or digital media such as compact disc, DVD and the internet. I understand I will receive no compensation, financial or otherwise for the use now or at any time in the future, of my testimonials and images. When used for professional marketing, I understand that my images will not be personally identifiable such as using my name or displaying my full face unless I give consent by initialing the following paragraph.

(Initial)_____I hereby give my consent to have my personally identifiable testimonials and images utilized by Crabtree Dental, Dr. Crabtree, and his team for the purpose of professional marketing. The purpose of this marketing is to help other patients and prospective patients understand the benefits of services rendered by this office. I understand that my images and/or testimonials may be used in a portfolio of cases representing Dr. Crabtree's dental work. This portfolio may be in paper or digital format. My images and testimonials may be used for marketing purposes in the form of print media, video, television or digital media such as compact disc, DVD and the internet. I understand I will receive no compensation, financial or otherwise for the use now or at any time in the future, of my testimonials and images.

(Initial)_____I hereby release Dr. Crabtree, Crabtree Dental, Ronald K. Crabtree D.D.S. P.A., and successors from any claims that I have or may have arising from such use, including but not limited to defamation, invasion of privacy, copyright infringement or any other cause of action arising from such use.

This consent and release will remain in effect until cancelled in writing. Any cancellation will not affect the usability of images that have already been released.

Consent given for: _____

Print Patient's Name

Signature: _____ Date: _____

Patient or Responsible Party if patient is a minor

Ronald K. Crabtree D.D.S., P.A.

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. 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 September 23, 2013, 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. 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, and we will 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 using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION - We will use and disclose your health care records for the purpose of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. For example, we may need to share information with other healthcare providers or specialists involved in your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities and utilization review. For example we may disclose treatment information when billing a dental plan for dental services provided to you.

Healthcare Operations include the business aspects of running our practices. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may remind you of appointments or that it is time for you to contact us and make an appointment. If you have a health condition that warrants it, appointment postcards may remind you to premedicate prior to your 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 various communications may include postcards, letters, telephone or electronic reminders such as email or text messages. Messages may be left at home and/or work or on your mobile phone. If you were referred to our office by a referral service or marketing organization, we may confirm with them that you have become a patient in our practice. If an individual such as a friend, patient, acquaintance or family member referred you to our practice we may thank them for the referral. If you were referred to our practice by a charitable organization such as Katy Christian Ministries or Texas Dentists for Healthy Smiles, we will use or disclose the minimal necessary health care information to them in order to coordinate your treatment.

Written Authorization for disclosures of information other than for TPO: We will 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). 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. 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.

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. 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 prescriptions, dental supplies, x-rays, or other similar forms of health information.

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 institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

PATIENT RIGHTS – You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our privacy officer at the practice address listed below. Additionally, forms are available from our office to help facilitate your request. Your specific rights are listed below.

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.) If you request copies, we will charge $25 for the first 20 pages and $0.50 per page for each copy thereafter. If you request duplicates of radiographs, the duplication charge will be $25 for panorex or full mouth series, and $15 per intra oral radiograph. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

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. 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 these additional requests.

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 purpose 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 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.

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

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.

You have the right to file a formal, written complaint with us at the address on this notice. You have the right to file a complaint with the U.S. Department of Health & Human Services in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Privacy Officer: Kristy Crabtree ● 23056 Westheimer Pkwy, Katy, TX 77494 ● (281)347-1960