PATIENT INFORMATION QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ MI ____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

PREFERRED NAME _____ HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

STREET ADDRESS _____ CITY _____ ZIP CODE _____ E-MAIL _____

HOW DID YOU HEAR ABOUT US? _____ PHARMACY LOCATION _____ PHARMACY PHONE # _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

HOME PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME _____ INSURANCE ADDRESS _____ INSURANCE PHONE # _____

SUBSCRIBER'S NAME _____ PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT SUBSCRIBER'S DOB _____ SUBSCRIBER'S ID # _____

GROUP/PROGRAM # _____ EMPLOYER _____

CONFIRMATIONS

HOW WOULD YOU LIKE US TO CONFIRM YOUR APPOINTMENTS? *(PLEASE CIRCLE ALL THAT APPLY)*: CALL TEXT EMAIL

I CONSENT TO MAKING OF VIDEOTAPES, PHOTOGRAPHS, X-RAYS BEFORE, DURING & AFTER TREATMENT, & TO USE THE SAME BY THE DR IN SCIENTIFIC PAPERS OR DEMONSTRATIONS.

I CERTIFY THAT I HAVE READ THIS FROM AND AGREE WITH ITS CONTENTS.

_____

PATIENT'S SIGNATURE *(OR SIGNATURE OF PARENT IF PATIENT UNDER AGE 18)* **DATE**

MEDICAL HISTORY

PATIENT NAME _____ NICKNAME _____ AGE _____

NAME OF PHYSICIAN & THEIR SPECIALTY _____

MOST RECENT PHYSICAL EXAMINATION _____ PURPOSE _____

WHAT IS YOUR ESTIMATE OF YOUR GENERAL HEALTH? _____ EXCELLENT _____ GOOD _____ FAIR _____ POOR _____

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury	____	____
2. An allergic reaction to		
_____aspirin, ibuprofen, acetaminophen, codeine		
_____penicillin		
_____erythromycin		
_____tetracycline		
_____sulpha		
_____local anesthetic		
_____fluoride		
_____metals (nickel, gold, silver, _____)		
_____latex		
_____other		
3. Heart problems or cardiac stent within the last 6 months	____	____
4. History of Infective endocarditis _____	____	____
5. Artificial heart valve, repaired heart defect (PFO) ____	____	____
6. Pacemaker or implantable defibrillator _____	____	____
7. Artificial prosthesis 9heart valve or joints _____	____	____
If so, date of surgery _____		
8. Rheumatic or scarlet fever _____	____	____
9. High or Low Blood pressure _____	____	____
10. A stroke (taking blood thinners) _____	____	____
11. Anemia or other blood disorder _____	____	____
12. Prolonged bleeding due to slight cut (INR >3.5) _____	____	____
13. Emphysema, Sarcoidosis _____	____	____
14. Tuberculosis _____	____	____
15. Asthma _____	____	____
16. Breathing or sleep problems (i.e. Snoring, sinus) _____	____	____
17. Kidney disease _____	____	____
18. Liver Disease _____	____	____
19. Jaundice _____	____	____
20. Thyroid, parathyroid disease, or Calcium Deficiency _	____	____
21. Hormone Deficiency _____	____	____
22. High Cholesterol _____	____	____
23. Diabetes (HbA1C= _____) _____	____	____
24. Stomach or Duodenal Ulcer _____	____	____
25. Digestive Disorders (i.e. Gastric Reflux) _____	____	____

	YES	NO
26. Osteoporosis/osteopenia (ie. Taking bisphosphonates)	____	____
27. Arthritis _____	____	____
28. Glaucoma _____	____	____
29. Contact lenses _____	____	____
30. Head or neck injuries _____	____	____
31. Epilepsy, convulsions (seizures) _____	____	____
32. Neurologic problems (Attention Deficit Disorder) _____	____	____
33. Viral infections & cold sores _____	____	____
34. Any lumps or swelling in the mouth _____	____	____
35. Hives, skin rash, hay fever _____	____	____
36. Venereal disease _____	____	____
37. Hepatitis (Type _____) _____	____	____
38. HIV / AIDS _____	____	____
39. Tumor, abnormal growth _____	____	____
40. Radiation therapy _____	____	____
41. Chemotherapy_____	____	____
42. Emotional problems _____	____	____
43. Psychiatric treatment _____	____	____
44. Antidepressant medication _____	____	____
45. Alcohol/ other dependency _____	____	____
Are you:		
46. Presently being treated for any other illness_____	____	____
47. Aware of a change in your general health _____	____	____
48. Taking medication for weight management (i.e. Fen-phen)	____	___
49. Taking dietary supplements _____	____	____
50. Often exhausted or fatigued _____	____	____
51. Subject to frequent headaches _____	____	____
52. A smoker or smoked previously _____	____	____
53. Often unhappy or depressed _____	____	____
54. FEMALE: taking birth control pills _____	____	____
55. FEMALE: pregnant _____	____	____
56. MALE: prostate disorders _____	____	____

DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, OR OTHER TREATMENT THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT:

_____

LIST ALL MEDICATIONS, SUPPLEMENTS, &/OR VITAMINS TAKEN WITHIN THE LAST 2 YEARS:

(Ask for an additional sheet if you are taking more than 6 medications)

DRUG	PURPOSE	DRUG	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

PATIENT'S SIGNATURE: _____ **DATE :** _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

DENTAL HISTORY

REFERRED BY _____ HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH? Excellent Good Fair Poor

PREVIOUS DENTIST _____ HOW LONG HAVE YOU BEEN A PATIENT? _____ (MONTHS/YEARS)

DATE OF MOST RECENT DENTAL EXAM: _____ DATE OF MOST RECENT X-RAYS: _____

DATE OF MOST RECENT TREATMENT (OTHER THAN A CLEANING): _____

I ROUTINELY SEE MY DENTIST EVERY: 3 MOS 4 MOS 6 MOS 12 MOS NOT ROUTINELY

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

1. Are you fearful of dental treatment? _____ YES NO
2. Have you ever had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications in past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? YES NO
5. Did you ever have braces, orthodontic treatment, or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change?_____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? __ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE & JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) YES NO
12. Do you have any problems chewing gum? _____ YES NO
13. Do you have any problems chewing bagels, baguettes, protein bars, or other hard foods? __ YES NO
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
15. Are your teeth crowding or developing spaces? _____ YES NO
16. Do you have more than one bite & squeeze to make your teeth fit together? _____ YES NO
17. Do you chew ice, bite your nails, use your teeth to old objects, or have any other oral habits? YES NO
18. Do you clench your teeth in the daytime or make them sore? _____ YES NO
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
20. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years? _____ YES NO
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? YES NO
23. Do you feel or notice any holes (ie. pitting, craters) on the biting surface of your teeth? _____ YES NO
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part or your mouth? _____ YES NO
25. Do you have grooves or notches on your teeth near the gumline? _____ YES NO
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
27. Do you get food caught between any teeth? _____ YES NO

GUM AND BONE

28. Do your gums bleed when brushing or flossing? _____ YES NO
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ____ YES NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
31. Is there anyone with a history or periodontal disease in your family? _____ YES NO
32. Have you ever experienced gum recession? _____ YES NO
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty? eating an apple? _____ YES NO
34. Have you experienced a burning sensation in your mouth? _____ YES NO

PATIENT'S SIGNATURE: _____ **DATE :** _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

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 OUT PRIVACY PRACTICES., OUR LEGAL DUTIES, & YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION. WE MUST FOLLOW THE PRVACY PRACTICES THAT ARE DESCRIBED IN THIS NOTICE WHILE IT IS IN EFFECT. THIS NOTICE TAKES EFFECT JUNE 1, 2019 AND WILL REMAIN IN EFFECT UNTIL WE REPLACE IT.

WE MAY CHANGE OUR PRIVACY PRACTICES FROM TIME TO TIME. IF WE DO, WE WILL REVISE THIS NOTICED SO YOU WILL HAVE AN ACCURATE SUMMARY OF OUR PRACTICES. THE REVISED NOTICE WILL APPLY TO ALL OF YOUR HEALTH INFORMATION. WE MAY ALSO REVISE THE NOTICE FROM TIME TO TIME. IF WE MAKE AN MATERIAL REVISIONS TO THIS NOTICE, WE WILL PROVIDE YOU WITH A COPY OF THE REVISED NOTICE WHICH WILL SPECIFY THE DATE ON WHICH SUCH REVISED NOTICE BECOMES EFFECTIVE. WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE THAT IS CURRENTLY IN EFFECT. FOR MORE INFORMATION ABOUT OUR PRIVACY PRACTICES OR FOR DDITIONAL COPIES OF THEIS NOTICE, PLEASE CONTACT US USING THE INFORMATION LISTED AT THE END OF THIS NOTICE.

USES AND DISCLOSURES OF HEALTH INFORMATION

A. USE & DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

WE MUST DISCLOSE YOUR HEALTH INFORMATION TO YOU, AS DESCRIBED IN THE PATIENT RIGHTS SECTION OF THIS NOTICE. WE ALSO USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. FOR EXAMPLE:

- **TREATMENT;** WE MAY DISCLOSE YOUR HEALTH INFORMATION TO A PHYSICIAN OR OTHER HEALTH CARE PROVIDER PROVIDING TREATMENT TO YOU.
- **PAYMENT**: WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION TO PBTAIN PAYMENT FOR SERVICES WE PROVIDE TO YOU.
- **HEALTH CARE OPERATIONS:** WE MAY USE AND DISCLOSE INFORMATION IN CONNECTION WITH OUR HEALTH CARE OPERATIONS, INCLUDING QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, REVIEW OF THE COMPETENCE OR QUALIFICATIONS OF HEALTH CARE PROFESSIONSALS, EVALUATION OF PRACTITIONER AND PROVIDER PERFORMANCE, TRAINING PROGRAMS, ACCREDITATION, AND LICENSING AND CREDENTIALING ACTIVITIES.

YOUR AUTHORIZATION: IN ADDITION TO OUT ISE OF YOUR HEALTH INFORMATION IN CONNECTION WITH OUR HEALTH CARE OPERATIONS, INCLUDING QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, REVIEW OF THE COMPETENCE OR QUALIFICATIONS OF HEALTH CARE PROFESSIONSALS, EVALUATION OF PRACTITIONER AND PROVIDER PERFORMANCE, TRAINING PROGRAMS, ACCREDITATION, CERTIFICATION, AND LICENSING AND CREDENTIALLING PROGRAMS.

DISCLOSURES TO FAMILY AND FRIENDS: WE MAY DISCLOSE YOUR HEALTH INFORMATION TO A FAMILY MEMBER, FRIEND, OR OTHER PERSON IDENTIFIED BY YOU TO THE EXTENT NECESSARY TO HELP WITH YOUR HEALTH CARE OR WITH PAYMENT FOR YOUR HEALTH CARE, BUT ONLY IF YOU AGREE THAT WE MAY DO SO.

DISCLOSURES TO PERSONS INVOLVED IN YOUR CARE: WE MAY ALSO 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 YOU CARE, OF YOUR LOCATION, GENERAL CONDIITON OR DEATH. IF YOU ARE PRESENT, THEN PRIOR TO USE OR DISCLOSURE OF YOUR HEALTH INFORMATION, WE I'LL PROVIDE YOU WITH AN OPPORTUNITY TO OBJECT TO SUCH USE OR DISCLOSURE. IN THE EVENT OF YOUR INCAPACITY OR EMERGENCY CIRCUMSTANCES, WE WILL DISCLOSE HEALTH INFORMATION BASED ON A DETERMINATION USING OUR PROFESSIONAL JUDGEMENT, AND WE WILL DISCLOSE ONLY HEALTH INFORMATION THAT IS DIRECTLY RELEVANT TO THE PERSON'S INVLOVEMENT IN YOUR HEALTH CARE. WE WILL ALSO USE OUR PROFESSIONAL JUDGEMENT AND OUR EXPERIENCE WITH COMMON PRACTICE TO MAKE RESONABLE 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.

APPOINTMENT REMINDERS: WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION TO PROVIDE YOU WITH APPOINTMENT REMINDERS (SUCH AS VOICEMILS, POSTCARDS, LETTERS).

PATIENT-RELATED COMMUNICATION: WE MAY USE OR DICLOSE YOUR HEALTH INOFRMATION TO PROVIDE PATIENT-RELATED COMMUNICATION SUCH AS INTRAORAL PHOTOGRAPHY, "NO CAVITY CLUD" FOR CHILDREN, AND TELEPHONED-IN AND FAXED-IN PRESCRIPTIONS.

MARKETING HEALTH-RELATED SERVICES: WE WILL NOT USE YOUR HEALTH INFORMATION FOR MARKETING COMMUNICATION WITHOUT YOUR WRITTEN AUTHORIZATION.

B. USE AND DISCLOSURE FOR THE PUBLIC NEED

IN PARTICULAR SITUATIONS INVOLVING THE PUBLIC NEED, WE MAY DISCUSS YOUR HEALTH INFORMATION WITHOUT OBTAINING YOUR AUTHORIZATION. THOSE SITUATIONS INCLUDE THE FOLLOWING CIRCUMSTANCES:

REQUIRED BY LAW: WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WHEN WE ARE REQUIRED BY LAW TO DO SO.

PUBLIC HEALTH ACTIVITIES: WE MAY DISCLOSE YOUR HEALTH INFORMATION TO AUTHORIZED PUBLIC HEALTH OFFICIALS SO THEY MAY CARRY OUT THEIR PUBLIC HEALTH ACTIVITIES. FOR EXAMPLE, WE MAY SHARE YOU HEALTH INFORMATION WITH GOVERNMENT OFFICIALS THAT ARE RESPONSIBLE FOR CONTROLLING DISEASE, INJURY OR DISABILITY.

HEALTH OVERSIGHT ACTIVITES: WE MAY RELEASE YOUR HEALTH INFORMATION TO GOVERNMENT AGENCIES AUTHORIZED TO CONDUT AUDITS, INVESTIGATIONS, AND INSPECTIONS, AS WELL AS CIVIL, ADMINISTRATIVE OR CRIMINAL INVESTIGATIONS, PROCEEDINGS OR ACTIONS.

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.

PRODUCT MONITORING, REPAIR AND RECALL: WE MAY DISCLOSE YOUR HEALTH INFORMATION TO A PERSON OR COMPANY THAT IS REGULATED BY THE FOOD AND DRUG ADMINISTRATION FOR THE PURPOSE OF: (1) REPORTING OR TRACKING PRODUCT DEFECTS OR PROBLEMS; (2) REPAIRING, REPLACING, OR RECALLING DEFECTIVE OR DANGEROUS PRODCUTS; OR (3) MONITORING THE PERFORMANCE OF A PRODUCT AFTER IT HAS BEEN APPROVED FOR USE BY THE GENERAL PUBLIC.

LAWSUITS AND DISPUTES: WE MAY DISCLOSE YOUR HEALTH INFORMATION IF WE ARE ORDERED TO DO SO BY A COURT OR ADMINISTRATIVE TRIBUNAL THAT IS HANDLING A LAWSUIT OR OTHER DISPUTE. WE MAY ALSO DISCLOSE YOUR HEALTH INFORMATION IN RESPONSE TO A SUBPOENA, DISCOVERY REQUEST, OR OTHER LAWFUL REQUEST BY SOMEONE ELSE INVOLVED IN THE DISPUTE, BUT ONLY IF EFFORTS HAVE BEEN MADE TO TELL YOU ABOUT THE REQUEST OR TO OBTAIN A COURT ORDER PROTECTING THE INFORMATION FROM FURTHER DISCLOSURE.

Lago Dental Center

Dr. Bonny Grigor

6015 Lohman Ford Rd, Suite 103, Lago Vista, TX 78645

Office (512)267-5200 / Fax (512)267-0600

LAGO
DENTAL CENTER

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.
PLEASE PRINT PATIENT NAME

_____
PATIENT/GUARDIAN SIGNATURE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices but acknowledgement could not be obtained because:

- *Individual refused to sign*
- *Communication barriers prohibited obtaining the acknowledgement*
- *An emergency prevented us from obtaining acknowledgement*
- *Other (please specify):* _____

LAGO
DENTAL CENTER

FINANCIAL POLICY

INSURANCE: As a courtesy to you, LAGO DENTAL CENTER will facilitate your care by providing assistance with applicable dental insurance you may have. Insurance companies vary widely in the types of coverage they provide. Also, insurance companies will not quote exact payment for services not yet rendered, so until a claim is filed, we cannot tell you exactly how much your insurance company will pay.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. LAGO DENTAL CENTER is contracted with several major carriers to include: Ameritas, MetLife, Delta PPO and Premier, Humana PPO, United Concordia, & a few plans that have subsequently contracted with one of the fore-mentioned. Please call to verify your participation with your particular plan.

For your convenience, we accept all major credit cards, cash and checks. We deliver the finest care at the most reasonable cost to our patients; therefore, payment is due at the time service is rendered unless other arrangements have been made in advance. If you have questions regarding your account, please contact us at (512)267-5200. Many times, a simple telephone call will clear any misunderstandings.

Most insurance companies will respond within 4-6 weeks. Please call our office if your statement does not reflect your insurance payment within that time frame. If your insurance has not responded to our claim within 60 days, we ask that you take responsibility for resolving the claim with your insurance while making payments on your account**. Any remaining balance after your insurance has paid is your responsibility**. Your prompt remittance is appreciated. We can make arrangements for a monthly payment plan, but that must be implemented prior to the actual procedure.

PLEASE REMEMBER, YOU ARE FULLY RESPONSIBLE FOR ALL FEEES CHARGED BY THIS OFFICE REGARDLESS OF YOUR INSURANCE COVERAGE.

CANCELLATIONS: Last minute cancellations result in a loss of production without adequate time to rebook the appointment; therefore, **habitual cancellations & /or rescheduling without a 24-hour notice will be subject to a $50 CHAIR FEE**. Note: this may transfer to all family members.

SIGNATURE: _____ **DATE:** _____

LAGO
DENTAL CENTER

CANCELLATION/ NO SHOW POLICY

CANCELLATION/NO SHOW POLICY FOR DR APPOINTMENT:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment, Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

CANCELLATIONS: Last minute cancellations result in a loss of production without adequate time to rebook the appointment; therefore, **habitual cancellations & /or rescheduling without a 24-hour notice will be subject to a $50 CHAIR FEE**. Note: this may transfer to all family members.

SIGNATURE: _____ **DATE: _____**