HOMETOWN FAMILY DENTISTRY

PATIENT REGISTRATION

Patient's Information

First Name: _____ Preferred Name: _____ Last Name: _____ Middle Initial: ____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Soc Sec: _____ Driver's Lic: _____

E-mail: _____

Patient is: O Policy Holder O Responsible Party

Responsible Party Information (If Different than Above)

Responsible Party Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Soc Sec: _____ Driver's Lic: _____

DENTAL HISTORY

1. Purpose of Initial Visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
5. Previous dentist's name _____
6. When was the last time your teeth were cleaned? _____
7. Have you made regular visits? ..... YES NO

   How often? _____
8. Have you lost any teeth or have any teeth been removed? ..... YES NO

   Why? _____
9. Have they been replaced? ..... YES NO
10. Have you ever had any problems or complications with previous dental treatment? ..... YES NO
11. Do you clench or grind your teeth? Does your jaw click or pop? ..... YES NO
12. Have you experienced any pain or soreness in the muscles around your face or around your ears? ..... YES NO
13. Do you have frequent headaches, neck aches or shoulder aches? ..... YES NO
14. Does food get caught in your teeth? ..... YES NO
15. Are any of your teeth sensitive to: O Hot? O Cold? O Sweets? O Pressure?
16. Do your gums bleed or hurt? ..... YES NO
17. How often do you brush your teeth? _____ When? _____
18. Do you use dental floss? ..... YES NO
19. Are any of your teeth loose, tipped, shifted, or chipped? ..... YES NO
20. How do you feel about your teeth in general? _____
21. Are you interested in whitening your teeth? ..... YES NO
22. Do you have any questions or concerns? ..... YES NO

How did you find our office or who referred you here? _____

HOMETOWN FAMILY DENTISTRY

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Are you under a physician's care now? For what condition? O Yes O No If yes: _____

_____

Have you ever been hospitalized or had a major operation? O Yes O No If yes: _____

Have you ever had a serious head or neck injury? O Yes O No If yes: _____

Are you currently taking a blood thinner? O Yes O No Name of medication: _____

Do you take any medications, pills, or drugs? O Yes O No List medication names: _____

_____

_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? O Yes O No If yes: _____

Have you ever been told by a doctor or physician that you ALWAYS need to take an antibiotic before dental treatment? O Yes O No If yes: _____

Do you use tobacco? O Yes O No What form? How long? _____

Do you use controlled substances? O Yes O No If yes: _____

Women: Are you...
O Pregnant/Trying to get pregnant? O Nursing? O Taking oral contraceptives?

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Sulfa Drugs O Local Anesthetics O None
O Other: _____

Do you have, or have you had, any of the following?

AIDS / HIV Positive	O Yes O No	Convulsions	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Cortisone Medication	O Yes O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Diabetes	O Yes O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Drug Addiction	O Yes O No	High Blood Pressure	O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Easily Winded	O Yes O No	High Cholesterol	O Yes O No	Rheumatism	O Yes O No
Arthritis / Gout	O Yes O No	Emphysema	O Yes O No	Hives or Rash	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Epilepsy or Seizures	O Yes O No	Hypoglycemia	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Bleeding	O Yes O No	Irregular Heartbeat	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Excessive Thirst	O Yes O No	Kidney Problems	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Fainting Spells / Dizziness	O Yes O No	Leukemia	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Cough	O Yes O No	Liver Disease	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Glaucoma	O Yes O No	Lung Disease	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Hay Fever	O Yes O No	Mitral Valve Prolapse	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Heart Attack / Failure	O Yes O No	Osteoporosis	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Murmur	O Yes O No	Pain in Jaw Joints	O Yes O No	Tuberculosis	O Yes O No
Cold Sores / Fever Blisters	O Yes O No	Heart Pacemaker	O Yes O No	Parathyroid Disease	O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Trouble / Disease	O Yes O No	Psychiatric Care	O Yes O No	Ulcers	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes to medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

HOMETOWN FAMILY DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing 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 the 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, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Dr. Sarah Norman**
Telephone: **281-789-7728** Fax: **346-703-0234**
Email: **info@DentistInMagnolia.com**
Address: **7030 FM 1488 Rd, Suite 200, Magnolia, TX 77354**

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, and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT IF YOU WOULD LIKE.

Revocation of Consent (Only Sign if You Did NOT Sign Above)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you receive this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

HOMETOWN FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Signature: _____ Date: _____

RIGHT OF ACCESS FORM FOR FAMILY MEMBER OR FRIEND

Please list any persons other than yourself that we may discuss your information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name of the Individual Giving this Authorization: _____

Signature of the Individual Giving this Authorization: _____ Date: _____

FINANCIAL POLICY

You are legally responsible for payment on any treatment received at Hometown Family Dentistry. Insurance benefits are not a guarantee and you are financially responsible for any fees or portion that insurance does not cover. A $50 fee will be charged for no shows, missed appointments, and appointments cancelled with less than 24 hours advanced notice (one full business day that the office is open). Patients arriving late by 15 minutes or more will be charged the $50 missed appointment fee and will be rescheduled.

Accounts with an unpaid balance will acquire a $25.00 monthly fee. Any patient that is sent to collections for an unpaid balance will have a collection fee of 35% added to their balance. For any arranged payment plans that become delinquent a $25 fee will be added to each late payment until payments are current.

Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

For your convenience and ease of billing, we recommend that you leave a credit card on file for any unpaid fees not paid by insurance. Dental Insurance plans have become so complex that no dentist can estimate coverage exactly. When we receive an insurance payment, we notify you by phone of any additionally owed payment. In the event that we haven't heard from you within 48 hours, we will automatically bill your card the owed copayment.

I, _____ authorize **Hometown Family Dentistry** to charge my credit card to cover any unpaid fees not paid by insurance.

Card Type: _____ Name on Card: _____

Credit Card #:_____ Exp date: _____

CV Code: _____ (three digit code on back of card- Amex uses a 4 digit code)

Cardholder's Signature: _____ Date: _____

HOMETOWN FAMILY DENTISTRY

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. 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 location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also 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). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. 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 information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a 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 purposes 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 at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

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

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official Name: **Dr. Sarah Norman**
Telephone: **281-789-7728** Fax: **346-703-0234**
Email: **info@DentistInMagnolia.com**
Address: **7030 FM 1488 Rd, Suite 200, Magnolia, TX 77354**