PLEASE PRINT **PATIENT REGISTRATION**

First Name:________________________________Last Name:________________________________Middle Initial:________

Preferred Name:____ Patient is : □ Responsible Party □ Policy Holder

Patient Information:

Address: ____City, State, Zip:____

Home Phone:________________________Work Phone:________________________Cell Phone:________________________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: ________________Social Security #:______________________Drivers Lic#:________________________________

Employer:____

Preferred Pharmacy:_______________________________________ Pharmacy Phone #_________________________________

Referred By:______________________________________

Emergency Contact: Name & Relation to Patient____________________________ Emergency Contact Phone#_______________

Responsible Party: **(complete if someone other than the patient**)

First Name:________________________________Last Name:__________________________ Middle Initial:____________

Address:____City, State, Zip:____

Home Phone:________________________Work Phone:________________________Cell Phone:________________________

Birth date:____________________Social Security #:_____________________Drivers Lic#:______________________________

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Primary Insurance Information:

Name of Insured:__________________________________Insured Birth date:____________________________________

Insurance ID #:___________________________________Patient Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #:____________________________Employer:____

Insurance Company_________________________________Insurance Phone#:____________________________________

Address: ____ City, State, Zip:_______________________________________

Secondary Insurance Information:

Name of Insured:__________________________________Insured Birth date:____________________________________

Insurance ID #: ___________________________________Patient Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Insured Social Security #: ____________________________Employer:____

Insurance Company_________________________________Insurance Phone#:____________________________________

Address: ____ City, State, Zip:_______________________________________

Payment Agreement: **PLEASE NOTE: We are an "*Out of Network*" Provider** Return check charge $25.00

○ IN FULL TODAY

○ PARTIAL PAYMENT TODAY—FILE INSURANCE FOR BALANCE; HOWEVER, I UNDERSTAND THAT THE CO-PAY QUOTED TO ME IS AN ESTIMATE AND THAT **I AM RESPONSIBLE FOR ANY UNPAID CHARGE**.

○ PARTIAL PAYMENT TODAY – BALANCE AS AGREED UPON

*I CERTIFY THAT I AM THE PATIENT OR DULY AUTHORIZED GENERAL AGENT OF PAYMENT AUTHORIZED TO FURNISH THE INFORMATION REQUESTED, **I UNDERSTAND THAT EVEN THOUGH I HAVE SOME TYPE OF INSURANCE COVERAGE, I AM THE RESPONSIBLE FOR THE PAYMENT OF SERVICES**

________Patient Initials

MEDICAL HISTORY

PATIENT NAME ____ Birth Date ____________________________________

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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: ____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: ____
Are you taking any medications, pills, or drugs? Yes No If yes, please explain: ____
Do you take, or have you taken, Phen-Fen or Redux? Yes No
Have you ever taken Fosamax, Boniva, Actonel or any Treats or prevents weak bones (osteoporosis)
Other medications containing Bisphosphonates? Yes No .
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics

Other If yes, please explain:____

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

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain:
____
____
____

Comments:
____

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 in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____DATE ______________________

Privacy Policy Statement

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Privacy Officer: Practice Manager, 281.992.9900

Purpose: The following privacy policy is to ensure that **Dr. W. Daniel Gaffney, Jr., Endodontic Specialist (WDG Endo)** complies with requirements of the Health Insurance Portability & Accountability Act of 1996 (HIPPA) as well as California privacy protection laws and regulations. Protection of patient privacy is of paramount importance to **WDG Endo.** Violations of any of these provisions knowingly or unknowingly will result in disciplinary action including termination of employment and possible referral for criminal prosecution.

Notice of Privacy Practices
This Notice of Privacy Policy will be provided to patients at their first encounter and all uses and disclosures of protected health information (PHI) will be accord with **WDG Endo**'s notice of privacy practices. **WDG Endo** will have copies of the most current Notice of Privacy Policy available for review and for distribution at the reception desk.

Assigning Privacy and Security Responsibilities
Specific individuals at **WDG Endo** are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rules' requirements. At a minimum, **WDG Endo** will designate the Practice Manager as the privacy official.

Deceased Individuals
WDG Endo privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information
WDG Endo will ensure that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made for treatment purposes; to or as authorized by the patient; or as required by law for HIPAA compliance) such uses and disclosures of PHI must be limited to the minimum amount of information needed to accomplish the purpose of disclosure.

Verification of Identity
WDG Endo will ensure that the identity of all persons who request access to protected health information be verified before such access is granted.

Safeguards
Appropriate safeguards will be in place at **WDG Endo** to reasonably protect health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI and to PHI removed from **WDG Endo**.

Business Associates
WDG Endo will ensure business associates comply with the HIPAA Privacy Rules to the same extent as **WDG Endo**, and that they be contractually bound to protect health information to the same degree as set forth in this policy. Business associates permitted to receive PHI include, for example the patients' Dental insurers, and other Dental providers with whom we consult and coordinate patients' care or to whom we refer patients for specialized care.

Training and Awareness
WDG Endo will ensure that all employees are trained on the policies and procedures governing protected health information and how **WDG Endo** complies with the HIPAA Privacy. New employees will receive training within a reasonable time of employment.

Sanctions
WDG Endo will ensure that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records
WDG Endo will adhere to the HIPAA Privacy records retention requirement of six years. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at **WDG Endo**'s discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Complaints
WDG Endo will investigate and resolve all complaints relating to the protection of health in a timely fashion. All complaints will be directed to Practice Manager, who is duly authorized to investigate complaints and implement resolutions.

Prohibited Activities-No Retaliation or Intimidation
No employee or contractor of **WDG Endo** may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. No employee or contractor may condition treatment or payment on the provision of an authorization to disclose protected health information.

Cooperation with Privacy Oversight Authorities
WDG Endo will ensure that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services will receive cooperation in any investigation relative to protection of health information within **WDG Endo**. All personnel will cooperate fully with all privacy reviews and investigations.

Investigation and Enforcement
In addition to cooperation with Privacy Oversight Authorities, **WDG Endo** will follow procedures to ensure that investigations are supported internally and staff of **WDG Endo** will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if at all possible.

For more information about HIPPA or to file a complaint:
http://www.hhs.gov/ocr/hipaa/ the hotline is 1-866-627-7748 (voicemail)

Dr. W. Daniel Gaffney, Jr., Endodontic Specialist

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Last Updated January 2013

This Acknowledgement of Receipt of the HIPAA Notice of Privacy Practices ("Acknowledgement") is being provided by Dr. W. Daniel Gaffney, Jr., Endodontic Specialist as a courtesy to its customers and is not legal advice nor intended to be relied on as legal advice. This Acknowledgement is intended to comply only with the federal HIPAA Privacy Rule requirements. HIPAA requires a dental practice to make a good faith effort to obtain a signed Acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

Dr. W. Daniel Gaffney, Jr., Endodontic Specialist

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

____
Patient Name (Please Print)

______________________________ ______________________________
Patient Signature Date

-OR-

____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: ______________________________

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:____

______________________________ ______________________________
Staff Member Signature Date

CONSENT FOR TREATMENT

I, *(please print name)*________________________________, understand Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal therapy may require retreatment, surgery, loss of dental prosthesis or extraction. I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, bridge, etc.) will be done by my regular dentist.

Texas Law now requires informed consent understood and signed by you before dental treatment. You must be informed of all risks of the procedure to be done and medications to be given no matter how rare.

Some risks associated with the procedures include fracture or loss of teeth, continued pain, infection, swelling, bleeding, trimus (restricted jaw opening), discoloration, the need for additional treatment or surgery, difficulty with diagnosis especially if more than one tooth needs treatment at the same time, inability to diagnose all crown or root fractures, paresthesis (numbness, tingling), separated instruments, overextension of filing material, inability to negotiate all canals, damage to your present restoration and swallowing or aspiration of foreign objects.

Some risks associated with the medication include: allergic reactions (rash, itching, swelling, death), gastrointestinal problems (nausea, vomiting, diarrhea, colitis), cardiovascular problems (shortness of breath, respiratory depression) and neurological problems (drowsiness, coma, paralysis).

Texas Law also requires us to mention the risks of brain damage, or disfiguring scars associated with such procedures. Complications may require hospitalization and may even result in death

I have read the preceding risks that may occur in connection with this procedure. I believe I have been given and understand sufficient information to give my consent to the above treatment and for Dr. W. Daniel Gaffney to administer anesthetics and medication he deems necessary for the care of the patient named above.

SIGNED:

PATIENT:____

LEGALLY RESPONSIBLE PERSON:____

RELATIONSHIP: (circle) Parent, Legal Guardian

DATE:____________________________________WITNESS:____