MI CASA
FAMILY DENTISTRY

New Patient Information

About You

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Email: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Account if Other than Patient

Name: _____ Relation to Patient: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation to you: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse Information

Name: _____ Birth Date: _____ Social Security #: _____

Employer: _____ Phone: _____ Work Phone: _____

Insurance Information

Primary Insurance Company: _____ Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's ID #: _____ Group #: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone: _____ Insurance Company Fax: _____

Secondary Insurance Company: _____ ___ Policy Holder: _____

Policy Holder's Date of Birth: _____ Policy Holder's ID #: _____ Group #: _____

Insurance Company Address: _____ City: _____ State: _____ Zip: _____

Insurance Company Phone: _____ Insurance Company Fax: _____

PAYMENT IS DUE AT TIME OF SERVICE

I understand that I am responsible for payment of services rendered by Mi Casa Family Dentistry, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the Onsite Dental to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

FINANCIAL AGREEMENT

For my conveniece, this office may release information to my insurance and receive payments directly from them.
If sent to collections, I agree to pay a $30 collection fee and all related fees and court costs.
Every effort will be made to collect payment from my insurance. But if they do not pay as expected, I am responsible.
Treatment plans and clinical circumstances may change. I will be financially responsible for the actual treatment completed.

MEDICAL HISTORY

Name of Medical Doctor: _____ Doctor City / State: _____

Emergency Contact: _____ Emergency Phone Number: _____

List Medications You Are Now Taking:

Check Which Of The Following You Are Allergic To:

- ☐ None
- ☐ Aspirin
- ☐ Codein / Narcotics
- ☐ Latex Gloves
- ☐ Metals
- ☐ Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs

Other: _____

Check Any Medical Conditions You Have Had:

- ☐ None
- ☐ AIDS / HIV
- ☐ Alcohol / Drug Abuse
- ☐ Anemia / Leukemia
- ☐ Anorexia / Bulimia
- ☐ Arthritis
- ☐ Asthma / Hay Fever
- ☐ Blood Clot Problems
- ☐ Blood Transfusion
- ☐ Bronchitis
- ☐ Cancer / Tumor
- ☐ Cardiac Pacemaker
- ☐ Chest Pain
- ☐ Damaged Heart Valve
- ☐ Diabetes
- ☐ Dry Mouth / Sjogren
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting / Seizures
- ☐ Fever Blister / Herpes
- ☐ Frequent Headaches
- ☐ Gall Bladder Trouble
- ☐ Heart Attack / Stroke
- ☐ Heart Disease / Angina
- ☐ Heart Murmur
- ☐ Hepatits / Jaundice
- ☐ High Blood Pressure
- ☐ Hives / Skin Rash
- ☐ Joint Replacement
- ☐ Kidney / Bladder Trouble
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Health Problems
- ☐ Mitral Valve Prolapse
- ☐ Persistent Diarrhea
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Sexually Transmitted Disease
- ☐ Sinus Trouble
- ☐ Stomach Ulcers
- ☐ Thyroid Problems
- ☐ Tuberculosis

Other: _____

Do you use tobacco? If so, what kind and how much? _____

Do you have any unusual reactions to dental injections? _____

Are you pregnant or have any reason to believe you may be? ☐ Yes ☐ No

Do you take vitamin supplements?	☐ Yes	☐ No	Do you take weight loss supplements?	☐ Yes	☐ No
Do you purchase primarily organic foods?	☐ Yes	☐ No	Do you take work out supplements?	☐ Yes	☐ No
Do you take meal replacement shakes?	☐ Yes	☐ No	Do you drink energy drinks?	☐ Yes	☐ No

Do you wish your smile was prettier?	☐ Yes	☐ No	Do you have any missing teeth?	☐ Yes	☐ No
Do you have crooked teeth?	☐ Yes	☐ No	Do you have any dental pain?	☐ Yes	☐ No

Reason for today's visit:

By signing below I certify that all of the above information is true to the best of my knowledge.

Name of Patient / Guardian (printed) _____ Signature _____ Date _____

MI CASA
FAMILY DENTISTRY

5405 S. Pleasant Valley Rd.
Ste# 108
Austin TX. 78744
Phone# (512)229-0401

Consent to share confidential information

"I _____ give **Mi Casa Family Dentistry** permission to share any of my personal information with the following people:

1. _____ Relation: _____ DOB: _____
2. _____ Relation: _____ DOB: _____

X _____ **Date:** _____

Patient / Legal Guardian Signature

MI CASA
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. 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 (10/06/16), 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. Before we make a significant change in our privacy practices, we will change this Notice and 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 use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Business associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement between our practice and the business associate to assure the protection and privacy of your PHI.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. 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 filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

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. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. 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 you $2.00 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

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, but not before April 14, 2003. 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 that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alterative 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.

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.

If you are concerned that we may have violated your privacy rights, or 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 alterative 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.

MI CASA
FAMILY DENTISTRY

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.

Name of Patient (or parent if under 18 years)

_____

Patient Name (printed)

_____

Signature of Patient (or parent if under 18 years)

_____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____
  _____

_____ _____

Employee Signature Date