General Dentistry
325 N. St. Paul, Ste 1150
DALLAS, TEXAS 75201
Phone: (214) 871-1022
Fax: (214)871-3368
www.downtowndallasdentistry.com

Located across from the St. Paul Station of the Dart Light Rail

Patient Information

DATE					
Patient name		Preferred Phone#			
Home address					
City		State		Zip	
How long at this address		☐ Own ☐ Rent			
Date of birth		SSN			
HomePhone		Cell Phone		Work phone	
Employer		Occupation			
How long with this Employer		Work fax			
Marital status		Spouse name			
Name and age of children					
Email address					

Insurance Information

Insurance Company		Phone	
Business Address			
City/State/Zip			
Plan/Group Number			
Name of Insured		Insured SSN	
Insured Employer		Date of Birth	

Emergency Contact Information

Who should we call in case of emergency?			
Relationship		Phone	

Medical Information

Former dentist	How long since last visit
Are you satisfied with past dental treatment? ☐ yes ☐ no	
Preference of appointment day/time	
Are you happy with your smile? ☐ yes ☐ no	
What would you change if you had the opportunity? Please describe below	
Do you have pain? ☐ yes ☐ no When did it start	
Have you had any problem with your gums	
Do they bleed ☐ yes ☐ no	If so how often
Are you apprehensive about dental treatment? ☐ yes ☐ no	
What in particular bothers you?	
Who may we thank for referring you?	
Have you used nitrous oxide gas when having dental treatment? ☐ yes ☐ no	

Are you allergic to any drugs or medication? ☐ yes ☐ no	If yes, please list below
Are you taking any medications/drugs at this time? ☐ yes ☐ no	If yes, please list below
Do you smoke or use tobacco products? ☐ yes ☐ no	

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY Have you ever had any of the following:		
☐ RHEUMATIC FEVER	☐ HIGH BLOOD PRESSURE	☐ VENEREAL DISEASE
☐ HEPATITIS	☐ LOW BLOOD PRESSURE	☐ ANY BLOOD DISORDER
☐ EPILEPSY	☐ TUBERCULOSIS	☐ HIV (+) OR (-)
☐ ANEMIA	☐ HEART MURMUR	
☐ DIABETES	☐ ANY HEART PROBLEMS	
JOINT REPLACEMENT(S) ☐ WHERE?		

Are you under a physician's care? ☐ yes ☐ no			
Physician's name		Phone # if known	
Address if known			
Date of last exam			
Is there a possibility that you could be pregnant? ☐ yes ☐ no			
Have you taken any steroids in the last past 6 months? ☐ yes ☐ no			
Please list below any medical conditions we should be aware of			

As I plan any treatment indicated for you, are you most comfortable controlling problems before they get more serious (proactive), or waiting until you become aware of the problem through pain, sensitivity or breakage (reactive)? ☐ Proactive ☐ Reactive
What do you consider to be the dentists' role in maintaining your dental health?
How often do you brush and clean your teeth ☐ daily ☐other
How often do you floss ☐daily ☐weekly ☐monthly
How can we serve you better or improve your visit with us?

<u>Appointment cancellation and “No Show” Appointments</u>

As a courtesy we routinely remind and confirm patients of their upcoming scheduled appointment, usually the day before and either directly or by a phone message if they are away from their desk. If unable to keep appointment, we request 24 hours notice.

<u>First cancellation or No-Show</u>: No charge. This is entered into the file, but is considered excused.

<u>Second event</u>: A charge will accrue and is payable before another appointment can be made.

<u>Third event</u>: So as not to raise fees for everyone to compensate for this expense by a few, we need to talk.

Steven G. Stutsman, DDS

Signature:_____________________________Date_____________

STEVEN G, STUTSMAN, D.D.S.
400 N. ST. PAUL, STE 310
DALLAS, TEXAS 75201
(214) 871-1022

Facts you should know about Dental Insurance

Dental insurance is rapidly playing a larger and larger role in helping people obtain dental treatment. Since we strongly feel our patients deserve the best possible dental care we can provide, and in an effort to obtain the high quality of care, we would like to share some facts about dental insurance with you.

Fact #1. Dental insurance is **NOT** meant to be a **PAY-ALL**; it is only meant to be an aid.

Fact #2. Many plans tell their insured that they will be covered "up to 80% or up to 100%. In spite of what you may have been told, we have found most plans cover about 60% to 70% of an average fee. Some plans pay more-some less. The amount your plans is determined by how much your employer paid for the plan. The less he paid for the insurance, the less you will receive.

Fact #3 It has been the experience of many dentists that some insurance companies tell their customers that "fees are above usual and customary fees" rather than saying to them that "our benefits are low". Remember – you get back only what your employer puts in less the profits of the insurance company.

Fact #4 Many routine dental services are NOT covered by insurance carriers.

Please do not hesitate in asking us any questions about our office policies. We want you to be comfortable in dealing with these matters and we urge you to consult us if you have any questions regarding our services and/or fees. We will file your insurance forms at no charge.

Although this office will do everything possible to maximize your insurance benefits. You are ultimately responsible for any portion of your account balance not paid by your insurance company, regardless of the reason.

If you have any questions regarding your insurance, we ask that you contact your company regarding the specifics and details of the plans it is conducting in your behalf.

I have read and understand the information contained in this document.

____ _______________________________
Patient Signature **Date**

Notice of Privacy Practices

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 (MM/DD/YR), 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.

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 $0.___ for each page, $___ 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 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.
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 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.

Contact Officer: Steven G. Stutsman, D.D.S.

Telephone: (214) 871-1022 Fax: (214) 871-3368

E-mail: info@downtowndallasdentistry.com

Address: 325 N. St Paul Street , Suite 1150, Dallas,TX 75201

Steven G. Stutsman, D.D.S., F.A.G.D.

GENERAL 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.

____

Please Print Name

____

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**

☐ **Other (Please specify)**

____

____

____