Little Elm Dental Care
800 W. Eldorado Parkway #124
Little Elm, TX 75068
972-292-3820

Patient's Name ____

Date of Birth ____

Social Security # ____

Male ___ Female ___ Minor ___

E – Mail Address ____

Street Address ____

City ______________________ State _________ Zip ____________

Home # ______________________ Work # ____________________

Cell # ________________________

Responsible Party for Patient_________________________________

Policy Holder Name ____

Date of Birth ____

Driver's License # ____

Social Security # ____

Insurance Company ____

Phone # ____

Employer of policy holder ____________________________________

Name of Medical Physician _______________________________________

Medical Physician Phone #_______________________________________

Date of last Medical Exam ________________________________

Are you under the care of a physician now? ___________Why?_____________

Please list ANY medications currently taking: ___________________________

____

List any known Allergies:____

Do you have any history of the following: Yes or No= Please check

Radiation treatment? ___ Anemia? ___ Diabetes? ___ Arthritis? ___

Rheumatic Fever? ___ Abnormal blood pressure? ___ Heart Cond.? ___

Hepatitis? ___ T.B? ___Asthma? ___ Aids/HIV positive? ___

Are you Allergic to?
Penicillin? Yes or No
Anesthetic? Yes or No
Food? Yes or No
Latex? Yes or No

Do you require pre-medication due to the following?
Heart Murmur? Yes or No
Joint Replacement? Yes or No

Pharmacy Name and Phone # ,_______________________________

____

Women: Are you pregnant? _____ If yes, Name and # Of OBGYN:_______

____

Previous dentist name, address and phone #? _______________________

____

Signature___________________________________Date_____________

Consent for Dental Treatment and Anesthesia

THIS IS MY CONSENT FOR LITTLE ELM DENTAL CARE OR ANY DENTIST WHO MAY BE EMPLOYED BY THEM TO PERFORM DENTAL TREATMENT INDICATED ON MY EXAMINATION CHART AND ANY OTHER PROCEEDURE DEEMED NECESSARY AS A CORROLLARY TO THE PLANNED OPERATION.

I ALSO AGREE TO THE USE OF TOPICAL AND LOCAL ANESTHETIC.
I UNDERSTAND THAT I MAY REQUEST ANALGESIA INHALTION (LAUGHING GAS) DEPENDING ON THE JUDGEMENT OF THE DOCTORS INVOLVED IN MY CARE.
USE OF ANALGESIA ANESTHESIA, AND OR MEDICATIONS THAT YOU HAD / HAVE RECENTLY TAKEN OCCASIONALLY CAUSE SOME COMPICATIONS.

SOME SIDE EFFECTS FOLLOWING DENTAL TREATMENT MAY INCLUDE ONE OR MORE OF THE FOLLOWING:

DRY SOCKET, INFECTION, SWELLWIN, BLEEDING, BRUISING OR DISCLORATION, TINGLING AND NUMBNESS AND THROMBOPHLEBITIS (INFLAMMATION OF THE VEIN) FROM INTRAVENOUS AND INTRAMUSCULAR INJECTIONS; INJURY TO ADJACENT TEETH OR RESTORATIONS INJURY TO SURROUNDING TISSUE, REFERRED PAIN TO THE EAR, NECK AND HEAD; NAUSEA AND VOMITING, ALLERGIC REACTION, CARDIOVASCULAR COLLAPSE OR OTHER CONDITIONS REQUIRING HOSPITALIZATION, ORAL SINUS OPENINGS WITH DELAYED HEALING AND POSSIBLY REQUIRING ADDITIONAL SURGERY, FRAGMENT OF TOOTH STRUCTURE (FROM SURGICAL EXCAVATION) REMAINING, SEPERATION OF ROOT CANAL FILE IN THE CANAL, FAILURE OF A ROOT CANAL THERAPY RESULTING IN AN EXTRACTION, POST OPERATIVE FRACTURE OF A TOOTH.

ANESTHETICS AND MEDICATIONS MAY CAUSE DROWSINESS AND LACK OF COORDINATION WHICH CAN BE INCREASED BY THE USE OF ALCOHOL OR OTHER DRUGS.
I HAVE BEEN ADVISED NOT TO OPERATE ANY VEHICLE OR HAZARDOUS DEVICE UNTIL FULLY RECOVERED FROM THE EFFECT OF THE ANESTHETIC OR MEDICATIONS THAT MAY HAVE BEEN GIVEN FOR MY DENTAL CARE.
I ACKNOWLEDGE THAT THE RECEIPT OF AND UNDERSTAND POST OPERATIVE INSTRUCTIONS AND WILL ARRANGE FOR A POST OPERATIVE (FOLLOW UP) VISIT.

SIGNATURE_________________________________DATE___________

LITTLE ELM DENTAL CARE
FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care to educate your family, and to create caring relationships in a compassionate, friendly atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered**.**

2. We accept cash, checks and credit cards: Visa, MasterCard, Discover, American Express and Care Credit

3. We accept most insurance. We are an in-network provider for some insurance companies and discount plans. However, it is your responsibility to verify that we are on your plan prior to your appointment. We will do our best to help you find out your benefits but the responsibility falls on you to ultimately know your plan**. We can ONLY provide you with an ESTIMENT**.

4. You must provide the office with a dental (not medical) insurance card with the proper mailing address of the insurance company, If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees.

5. You are responsible for paying all charges not covered by your insurance company, including deducible, and co- insurance all fees considered above your insurance company's usual and customary fee schedule. **Claim payments are NOT a guarantee**

6. **Your insurance benefits are a CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY AND YOUR EMPLOYEER. BENEFITS ARE NOT A GARENTEE.**

7. The office can not carry balances longer than 90 days; regardless of insurance payment, YOU are responcipal for FULL payment on account if no action is taken to clear the account, this office will be required to employ a collection service to collect payment. A $25.00 collection fee will be added to the account.

8. There will be a $30.00 charge for all returned checks.

AUTHORIZATION

1. I authorize Dr. James T. Grogan and staff to release any information concerning my case to my insurance company.

2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

______________________________ ______________________

Signature of Parent or Responsible Party Date

Little Elm Dental Care

800 W. Eldorado Pkwy #124
Little Elm, TX. 75068

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents r information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request

I, ____date____________________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and urgent changes in office policy. I understand that this consent shall remain in force from this time forward.

Directions

We are in the shopping center with, Little Elm Pharmacy,
Waters Edge Café and Mr. Jims Pizza
In the Lakeshore Shopping Center.

(Near Sonic, Taco Delight and Chicken Express)
In downtown Little Elm