CENTRAL TEXAS
ORAL HEALTH

COSMETIC AND FAMILY DENTISTRY

Welcome to Central Texas Oral Health! Please help us get to know you better by completing the following:

Personal Information:

Patient Name _____

Social Security # _____ Birthdate _____ /_____ /_____ Age _____

Address _____ City _____ Zip _____

E-mail _____

Home Phone _____ Mobile _____ Work _____

Employer_____ Occupation _____

Employer Address _____

Spouse/Partner or Guardian's Name _____

Phone _____

In case of emergency, whom should we contact? _____ Phone _____

Whom may we thank for referring you to our office? _____

How will you be making your payment today? _____

Primary Dental Insurance:

Person Responsible for your Account _____

Relationship to Patient _____ Birthday _____/_____/_____ Social Security # _____

Primary Dental Insurance Company _____

Group # _____

Subscriber ID # _____

Oral Health Information & History:

What prompted you to seek dental care at this time? _____

Are you in pain? □ Yes □ No

If yes, please explain _____

How long has it been since your last dental examination? _____

When did you last have a full mouth series of x-rays? _____

How long has it been since your last dental cleaning? _____

Have you ever been diagnosed with periodontal disease? □ Yes □ No

Have you ever had a deep cleaning? □ Yes □ No

Do your gums bleed? □ Yes □ No

What type of toothbrush do you use? □ Manual □ Electric

Do you floss daily? □ Yes □ No

Do you use fluoride toothpaste? □ Yes □ No

Do you use a mouth rinse? □ Yes □ No

Do you have any concerns about having dental treatment? _____

Have you ever had any serious problems associated with dental treatment? □ Yes □ No

If yes, please explain _____

Do you like the appearance of your teeth? □ Yes □ No

If no, please explain _____

Are you interested in whiter teeth? □ Yes □ No

Do you clench or grind your teeth? □ Yes □ No

Do you participate in any contact sports (i.e. football, basketball, lacrosse)? □ Yes □ No

Do you ever experience dry mouth symptoms? □ Yes □ No

Are any of your teeth sensitive? □ Yes □ No

Do you or have you ever-used tobacco in any form? □ Yes □ No

Have you ever had an oral cancer screening? □ Yes □ No

Health Information & History:

Are you currently under the care of a physician? □ Yes □ No

Physician's Name _____ Date of last physical exam_____

Physician's Address _____

Physician's Phone _____

Please list any medications, vitamins, and/or herbal supplements you are currently taking:

_____

_____

Please list any allergies that you have (i.e. medications, latex, metals, local anesthetics, etc.):

_____

_____

Please circle any of the following which you have or have been treated for in the past:

Acid Reflux
Anemia (low blood cell count)
Arthritis
Asthma
Bleeding Tendency (excessive)
Blood Disease
Cancer
Chemical Dependence (drugs/alcohol)
Chemotherapy
Chicken Pox
Chronic Fatigue Syndrome
Circulatory Problems
Congenital Heart Lesions
Cough (persistent or bloody)
Diabetes
Eating Disorder (Anorexia/Bulimia)
Emphysema
Epilepsy
Glaucoma
Heart Murmur
Heart Disease
Hepatitis (Type A / B / C)
Herpes
High Blood Pressure
HIV/ AIDS
Jaw Problems
Joint Replacement (Hip /Knee/ Other)
Kidney Disease
Latex Sensitivity
Liver Disease
Low Blood Pressure
Migraine Headaches
Mitral Valve Prolapse
Multiple Sclerosis
Nickel Sensitivity
Pacemaker
Periodontal Disease
Pneumonia
Prostate Problems
Psychiatric Care
Radiation
Recreational Drug Use
Respiratory Disease (lungs)
Rheumatic Fever
Scarlet Fever
Sexually Transmitted Diseases
Shortness of Breath
Sinus Trouble
Skin Rash
Snoring / Sleep Apnea
Stroke
Thyroid Problems
Tonsillitis
Tuberculosis
Ulcer
Weight Loss
Any Other Conditions: _____

_____

May we request a copy of your medical/dental records for our reference if necessary? □ Yes □ No

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your treatment:

_____

_____

_____

Is there any other information that you feel would be of value to us in your treatment?

_____

_____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. By signing below, I hereby certify that the above statements are true and correct. I also agree to let the doctor know if my health or medications change before my next appointment

_____
PRINTED NAME OF PATIENT

_____ _____
PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE — DATE

_____ _____
PROVIDER SIGNATURE — DATE

CENTRAL TEXAS
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COSMETIC AND 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 January 1, 2015 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 is 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 interferences 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 the 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 institutions or law enforcement officials having lawful custody of protected health information of inmates or patients 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 $25 up to 25 pages and $0.15 for every page after. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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 January 1, 2015. 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.

Restrictions: 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 your 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 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.

If you want more information about our privacy practices or have any questions or concerns, please contact us.

Contact Officer: Nazim Shahi
Telephone: 512-386-1229
Address: 5625 Eiger Road Suite 135, Austin, Texas 78735

CENTRAL TEXAS
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I have been provided with and understand Central Texas Oral Health PLLC's Notice of Privacy Practices. Central Texas Oral Health PLLC may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations as described in Central Texas Oral Health PLLC's Notice of Privacy Practices.

I give consent to Central Texas Oral Health PLLC to call me, leave voicemails, speak directly to family members answering my phone, and send mail and email to the addresses I provided, in reference to any items that assist the practice in carrying out treatment, payment, or operations, such as appointment reminders, billing information, insurance items, and any other information pertaining to my oral health.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Central Texas Oral Health PLLC is required to agree to the requested restrictions, if they are reasonable.

The restrictions I request are:

_____

_____

_____

I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

I have the right to request a copy of Central Texas Oral Health PLLC's Notice of Privacy Practices at any time.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct.

_____

PRINTED NAME OF PATIENT

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

CENTRAL TEXAS
ORAL HEALTH

COSMETIC AND FAMILY DENTISTRY

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS FROM PREVIOUS DENTIST

Please complete this form if you would like our office to request your dental records from your previous dentist. If your radiographs are older than one year OR are not of diagnostic quality, we may take new radiographs at your appointment.

I authorize the release of my dental records, including radiographs, to:

Central Texas Oral Health PLLC
5625 Eiger Road, Suite 135
Austin, Texas 78735

Phone: (512) 386-1229
Fax: (512) 394-5966

Email: office@centexoralhealth.com

Digital radiographs in Dexis format are preferred.

Dentist's Name _____

Dentist's Address _____

Dentist's Phone _____

_____
PRINTED NAME OF PATIENT

_____ _____
PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

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COSMETIC AND FAMILY DENTISTRY

GENERAL INFORMED CONSENT

I authorize Dr. Nazim K. Shahi (DMD) and/or his designated staff to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis I authorize Dr. Nazim K. Shahi (DMD) and/or his designated staff to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian. I understand that during treatment it may be necessary to change or add procedures to my treatment plan because of conditions found while treating the teeth that were not discovered during examination. I give my permission to Dr. Nazim K. Shahi (DMD) to make all changes and additions to my treatment plan, as necessary.

Medical History: I have disclosed all of my medical history including, but not limited to, any and all drugs and medications that I am currently taking and have taken within the last 72 hours. I have also disclosed all medications, foods, and other substances to which I am allergic.

Radiographs: I understand that Dr. Nazim K. Shahi (DMD) and/or his staff may need to take and evaluate radiographs (x-rays) to aid with proper diagnosis.

Local Anesthesia: I understand that local anesthesia is often used during dental treatment. I further understand that the risks of local anesthesia include, but are not limited to dizziness, nausea, vomiting, increases or decreases in heart rate, allergic reactions that may require medical management or hospitalization, restricted mouth opening, accidental self-injury from biting numb cheeks, lips, or tongue, and/or temporary or permanent numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste).

No Guarantee: I understand that dentistry is not an exact science and that, therefore, dentists cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Insurance: I assign all dental insurance benefits to which I am entitled to the extent permitted under my insurance policy to Central Texas Oral Health PLLC, and authorize Central Texas Oral Health PLLC to submit claim forms and receive payments directly with the notation “signature on file”. I authorize release of my treatment records, x-rays, and other matters in my file deemed pertinent to my insurance as requested. I agree to be responsible for payment of all services rendered by Central Texas Oral Health PLLC on my behalf or to my dependents. I agree that I am responsible for all unpaid claims.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct. My signature below also indicates that I am freely giving my informed consent to authorize Dr. Nazim K. Shahi (DMD) and any authorized staff to perform dental treatment.

_____

PRINTED NAME OF PATIENT

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN’S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

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APPOINTMENT POLICY

An appointment in our office is reserved specifically for you and the doctor or hygienist. To give full attention to you, we do not double book our schedule. We also leave room in our schedule for emergency patients who have urgent needs. Leaving this open space will create minimal impact on patients who have reserved an appointment.

- If you are unable to make your reserved time, we ask you to call our office during business hours at least 2 business days (48 hours) in advance.
- A "no-show" appointment is simply one where the patient does not call our office or leave a message in accordance with the above guideline.
- On the first no-show appointment, a non-refundable cancellation fee of $75 will be considered.
- On the second no-show appointment, you will be charged a non-refundable fee of $75.
- Any further no-shows may result in dismissal from our practice.

We understand life can be busy and unpredictable. If you are running late for an appointment, all we ask is that you call us to keep us informed. This will allow our schedule to flow as smoothly as possible. We will do all we can to adjust our schedule to get you in for your appointment. Our front desk staff will try to accommodate you as best as possible.

By signing below, I hereby certify that I have read and understand the above statements.

_____

PRINTED NAME OF PATIENT

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

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SOCIAL MEDIA / EDUCATIONAL USE AND DISCLOSURE CONSENT

Consent to Use and Disclose Treatment Information and Photographs for Social Media / Educational Purposes

We value our patients' right to privacy and confidentiality, and we take our responsibilities under HIPAA and the Texas Medical Records Privacy Act very seriously. The practice exercises great care in the use of patient images and patient identities to promote the practice via social media or for educational purposes. Specifically, we pledge not to disclose or discuss:

- Your identity and any past, present, or future health conditions;
- Discriminatory or potentially negative information of a personal or professional nature, and
- Past, present, or future payment for your dental care.

By signing below, you grant our office permission to use images of your dentition and/or oral soft tissues (lower 1/3 of your face) along with a brief description for promotional purposes via social media or for educational purposes at dental lectures, conferences, or symposiums.

You understand this authorization may be revoked at any time merely by notifying our office that you wish us to discontinue using your images and descriptions for promotional or educational purposes.

Finally, your willingness to participate in social media promotional or educational purposes will have no effect on the treatment you receive from our office or staff. If you decline to allow us to use your images and descriptions, your treatment or experience as a patient of our practice will not be affected.

By signing below, I hereby certify that I have read and understand the above statements.

_____

PRINTED NAME OF PATIENT

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE