Parmer Lane Family Dentistry
3704 W PARMER LN, AUSTIN, TX 78727-4120
(512) 255-7001
www.KEEPAUSTINSMILING.COM

NEW PATIENT FORM (UPDATED 2024)
| DOB:

New Patient Form (Updated 2024)

Patient Name:	
Preferred Name:	
Gender:	
Phone:	
Patient Date of Birth:	
Email:	
Mailing Address:	
SSN #:	
Marital Status:	
Referral Source:	
Employer:	
Occupation:	
Emergency Contact Name:	
Emergency Contact Phone:	
Emergency Contact Relationship:	

Patient's signature: Date:

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HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

Medical History

General Health Information	
Are you under a physician's care now?	
Have you ever been hospitalized or had a major operation?	
Have you ever had a serious head or neck injury?	
Are you taking any medications, pills, or drugs?	
Do you take, or have you taken, Phen-Fen or Redux?	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	
Are you on a special diet?	
Do you use tobacco?	
Do you use controlled substances?	
Women are you:	
Pregnant/Trying to get pregnant?	
Taking oral contraceptives?	
Breastfeeding?	
Are you allergic to any of the following?	
Aspirin	
Penicillin	
Codeine	
Acrylic	
Metal	
Latex	
Sulfa Drugs	
Local Anesthetics	
Other?	
Do you have, or have you had, any of the following?	
AIDS/HIV Positive	
Alzheimer's Disease	
Anaphylaxis	

Anemia	
Angina	
Arthritis/Gout	
Artificial Heart Valve	
Artificial Joint	
Asthma	
Blood Disease	
Blood Transfusion	
Breathing Problems	
Bruise Easily	
Cancer	
Chemotherapy	
Chest Pains	
Cold Sores/Fever Blisters	
Congenital Heart Disorder	
Convulsions	
Cortisone Medicine	
Diabetes	
Drug Addiction	
Easily Winded	
Emphysema	
Epilepsy or Seizures	
Excessive Bleeding	
Excessive Thirst	
Fainting Spells/Dizziness	
Frequent Cough	
Frequent Diarrhea	
Frequent Headaches	
Genital Herpes	
Glaucoma	
Hay Fever	
Heart Attack/Failure	
Heart Murmur	
Heart Pacemaker	
Heart Trouble/Disease	
Hemophilia	
Hepatitis A	
Hepatitis B or C	
Herpes	
High Blood Pressure	
High Cholesterol	
Hives or Rash	

Hypoglycemia	
Irregular Heartbeat	
Kidney Problems	
Leukemia	
Liver Disease	
Low Blood Pressure	
Lung Disease	
Mitral Valve Prolapse	
Osteoporosis	
Pain in Jaw Joints	
Parathyroid Disease	
Psychiatric Care	
Radiation Treatments	
Recent Weight Loss	
Renal Dialysis	
Rheumatic Fever	
Rheumatism	
Scarlet Fever	
Shingles	
Sickle Cell Disease	
Sinus Trouble	
Spina Bifida	
Stomach/Intestinal Disease	
Stroke	
Swelling of Limbs	
Thyroid Disease	
Tonsillitis	
Tuberculosis	
Tumors or Growths	
Ulcers	
Venereal Disease	
Yellow Jaundice	
Have you ever had any serious illness not listed above?	
Comments:	

Patient's signature: Date:

General Dentist's signature: Date:

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OFFICE POLICIES FORM
| DOB:

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 3704 W PARMER LN, AUSTIN, TX 78727-4120:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by

the author and filed separately from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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FINANCIAL POLICY

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Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be sent to collections if other arrangements have not already been made . If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $100 per hour that you were scheduled. Please help us maintain the highest quality of care by keeping scheduled appointments, and arriving 15 minutes prior to your appointments scheduled start time.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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DENTAL INSURANCE INFORMATION (UPDATED 2024)

| DOB:

Dental Insurance Information (Updated 2024)

Who is the insured member:	
Relationship to you:	
Member DOB:	
Members Address:	
Members Phone Number:	
Employer:	
Dental Insurance Company:	
Dental Insurance Phone Number:	
Dental Insurance Member ID:	
Dental Insurance Group ID:	
Dental Insurance Claims Address:	

Please take a picture of the front and back of your insurance card. If you do not have an insurance card please take a picture of the information displayed on the insurance company website that is specific to your insurance for dental.

Patient's signature: Date:

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HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM
| DOB:

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In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I want to provide the authorization	

Information Regarding Person Authorizing Releasing His/Her Information

Name of person authorizing release	
Date of Birth person authorizing release	
Personal Information to be released	
The above information may be released and/or received by	

The following is an authorization allowing Parmer Lane Family Dentistry to release information to whomever you designate. Parmer Lane Family Dentistry is authorized to make the disclosure of my benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a second person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want to add a third person/organization	
Name of person/organization that the office may release my information to	
Relation of person/organization that the office may release information to	
Phone number of person/organization that the office may release information to	
I want this consent to	

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient's signature: Date: