



Confidential Patient Information

Patient Name: _____ DOB: _____ Social Security No.: _____
Home Address: _____ City/State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ *Text OK? Yes or No* Work Phone: _____
Email: _____ Referred by: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Insured's Name: _____ Insured's Birthdate: _____ Social Security No.: _____
Employer: _____ Insurance Company: _____ Provider Phone: _____
Subscriber ID#: _____ Group Name: _____ Group No.: _____
Claim's Mailing Address: _____ City/State/Zip: _____
Relationship to Patient: _____ is the insured a current patient? Yes/No

Do you have any additional dental insurance? If so, please fill in information below

Insured's Name: _____ Insured's Birthdate: _____ Social Security No.: _____
Employer: _____ Insurance Company: _____ Provider Phone: _____
Subscriber ID#: _____ Group Name: _____ Group No.: _____
Claim's Mailing Address: _____ City/State/Zip: _____
Relationship to Patient: _____ is the insured a current patient? Yes/No

Consent for Services

I hereby authorize Leatherwood Family & Cosmetic Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate and also authorize Dr. Samantha Leatherwood to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I grant my permission to Leatherwood Family & Cosmetic Dentistry to leave messages via telephone, email, or text regarding future appointments. I am aware that Leatherwood Family & Cosmetic Dentistry follows HIPAA's privacy practices.

I understand that it is the policy of this office to require at least 48 hours advance notice for any cancellation or scheduling changes.

Signature

Printed Name

Date

Medical History

Physician: _____ Phone: _____ Date of Last Exam: _____

Please list any history of surgery and any complications: _____

Please list prescribed medications and non-prescribed supplements: _____

Has a physician recommended you to take premedication before dental appointments? _____

If yes, have you taken it as prescribed? _____

Women Only:

Are you pregnant or do you think you may be pregnant?

Yes No

Are you nursing?

Yes No

Are you taking birth control pills?

Yes No

Do you have or have you had any of the following (Check all that apply):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Thyroid | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> History of Cancer | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stomach Troubles/Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Pressure | |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Thyroid | |

Allergies or had any reaction to the following (Check all that apply):

- | | | | |
|---------------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Azithromycin | <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Tramadol | <input type="checkbox"/> Other(s): _____ |

Dental History

Reason for today's visit? _____

What are your goals for your oral health? _____

Date of last dental visit? _____ Date of last cleaning? _____ Date of last x-rays? _____

Please circle all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Broken Teeth or Fillings | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Old Silver Fillings | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Grinding Teeth or Clenching | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Jaw Soreness | <input type="checkbox"/> Crowns with Black Lines | <input type="checkbox"/> Sensitivity when Biting |
| <input type="checkbox"/> Jaw Locking Open/Closed | <input type="checkbox"/> Fractured Porcelain | <input type="checkbox"/> Spaces Between your Teeth |
| <input type="checkbox"/> Frequent Headaches/Migraines | <input type="checkbox"/> Chipped/Worn Teeth | <input type="checkbox"/> Crowded Teeth |
| <input type="checkbox"/> Previous Periodontal Treatment | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sores or Growths in Your Mouth |

Do you like the way your teeth look? _____ Do you have missing teeth you would like to replace? _____

Are you happy with the color of your teeth? _____ Are you interested in bleaching? Yes/No

If you could change anything about your smile, what would you change? _____

Please share any concerns about treatment, timing, finances, or anxiety: _____

Signature

Printed Name

Date



LEATHERWOOD
Family & Cosmetic Dentistry

Treatment Consent and Financial Policy

I hereby authorize Leatherwood Family & Cosmetic Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate and also authorize Dr. Samantha Leatherwood to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I understand that by consenting to treatment recommended by Dr. Samantha Leatherwood, I am complying with her standard of care for my dental health. The standard of care set forth by my insurance company sometimes will not coincide with Dr. Leatherwood's standard of care. Therefore, any charges not covered by insurance with regard to my dental treatment at Leatherwood Family & Cosmetic Dentistry are my responsibilities this will include but is not limited to:

- Exams
- Radiographs / Xrays necessary to diagnose dental disease and to remain compliant with the Texas State Dental Board of Examiners
- Teeth cleanings and periodontal therapy
- Fluoride
- All restorative dentistry procedures.

We are committed to providing you the best possible care available, regardless of the limitations insurance places on treatment. Our office is an in-network provider with most major PPO plans, in order to make your necessary dental treatment more affordable and we will file dental claims as a courtesy. However, our commitment is to you, our patient, not to an insurance company.

If your insurance company has not paid all remaining charges within 45 days of treatment, you will become responsible for the entire account balance. Insurance follow-up and reimbursement attempts also becomes your responsibility. We offer several options regarding financial agreements for your treatment.

*We appreciate your cooperation in this matter.
This will allow us to stay focused on our mission of achieving your oral health goals.*

Thank You,

Samantha Leatherwood, DMD

Signature

Printed Name

Date

Patient HIPAA Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received or been offered a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Signature

Printed Name

Date

I am also signing for my minor children: _____

Printed Names

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Signature

Printed Name

Date

I am also signing for my minor children: _____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

Office Personnel (signature)

Office Personnel (print name)

Date



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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect.

This Notice takes effect on January 1, 2014 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

Our Privacy Officer:
Samantha Leatherwood, DMD

Email:
leatherwooddentistry@gmail.com

Practice Contact Information:
4400 Teasley Lane
Suite 300
Denton, TX 76210
O: 940.220.5858