Gary L White, DDS

Date: _____

Patient Information

Patient Name: _____ Birth date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Spouse's name: _____

Social Security #: _____ Driver's License #: _____ State: _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Best number to reach you (circle): Home Work Cell Best time to call: _____

Email: _____

Address: _____
Street Apartment/Suite #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip

Emergency Contact: _____ Phone: _____
Last First

Responsible Party Information

Person financially responsible: ☐ Self (if responsible party is self, please skip to the next section)

☐ Other: _____ (please fill out information below)
Relationship to patient

Name of responsible party: _____
Last First MI

Social Security #: _____ Driver's License #: _____ State: _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Best number to reach you (circle): Home Work Cell Best time to call: _____

Email: _____

Address: _____
Street Apartment/Suite #

_____
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? _____
First Name Last Name

The above name is: ☐ Another patient, friend ☐ Another doctor ☐ Other: _____

Staff Initials: _____

Gary L White, DDS

Primary Insurance Information

Name of Insured: _____
Last First MI

Birth date: _____ Social Security #: _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Employer: _____

Employer Address: _____
Street City State Zip

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____
Street City State Zip

Plan Name or Number: _____ Group #: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Secondary Insurance Information

Name of Insured: _____
Last First MI

Birth date: _____ Social Security #: _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Employer: _____

Employer Address: _____
Street City State Zip

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____
Street City State Zip

Plan Name or Number: _____ Group #: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Staff Initials: _____

Gary L White, DDS

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for fully answering the following questions.

Are you now under a physician's care? ☐ No ☐ Yes; why?_____

Have you ever had a serious head or neck injury? ☐ No ☐ Yes; describe: _____

Have you ever had any complications following dental treatment? ☐ No ☐ Yes; describe:_____

Are you taking aspirin daily? ☐ No ☐ Yes

Are you taking Actonel, Boniva, or Fosamax? ☐ No ☐ Yes

Are you taking any other medication, including non-prescription medication and herbal supplements? ☐ No ☐ Yes; list:_____
_____

Do you use tobacco? ☐ No ☐ Yes, how many packs, dips, or chews per day? _____

Are you allergic to any of the following?

Aspirin····· Y N Penicillin····· Y N Codeine····· Y N Local Anesthetics····· Y N

Acrylic·····Y N Latex····· Y N Metals····· Y N Other: _____

Do you have or have you ever had any of the following? (Please circle 'Y' or 'N' for each condition)

Anemia ·····Y N
Arthritis or rheumatism·····Y N
Artificial heart valve*····· Y N
Asthma·····Y N
Back problems····· Y N
Blood disorders (i.e. Sickle cell) ···· Y N
Chemo or Radiation treatment·····Y N
Diabetes (Type I or Type II) ····· Y N
Drug addiction·····Y N
Emphysema·····Y N
Epilepsy or seizures·····Y N
Frequent headaches·····Y N
Gastric reflux·····Y N
Glaucoma····· Y N
Heart attack or angina····· Y N
Heart defect or murmur*····· Y N
Hepatitis A····· Y N
Hepatitis B or C·····Y N
High blood pressure·····Y N
HIV infection or AIDS·····Y N
Hemophilia, bleeding disorder····· Y N
Joint replacement or implant·····Y N
Kidney problems·····Y N
Liver disease····· Y N
Mitral valve prolapse*····· Y N
Pacemaker····· Y N
Rheumatic fever*·····Y N
Sexually transmitted disease·····Y N
Sinus problems·····Y N
Steroid (prednisone) treatment···Y N
Stroke····· Y N
Thyroid problems·····Y N
Tumors or growths·····Y N

☐ Other medical condition not listed above: _____

* Condition may require antibiotic medication before dental treatment

Women only: (Please circle 'Y' or 'N' for each)

Are you: Pregnant or think you might be pregnant···· Y N Nursing·····Y N
Taking oral contraceptives**·····Y N

** Antibiotic medication can interfere with the effectiveness of oral contraceptives.

Physician – Name: _____ Phone: _____

Pharmacy – Name: _____ Phone: _____

Would you like to know more about: ☐ Bleaching ☐ Veneers ☐ White fillings ☐ Porcelain crowns ☐ Implants

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

_____

Signature of patient, parent, or guardian Date

Staff Initials: _____

Payment of Services

Our office is a fee-for-service dental provider and payment is due at the time of service. Our office accepts cash, checks, credit cards (Visa, MasterCard, Discover), as well as most traditional insurance plans. Convenient financing of your dental treatment is available through Care Credit.

If you have dental insurance coverage, the estimated portion not covered by insurance is due at the time of service, and we will send you a statement for any remaining balance that insurance did not pay. If you prefer to pay your exact portion after your insurance company pays our office, a credit card is required to be kept on file. When the insurance payment is entered into your account, your remaining balance is automatically charged to the credit card linked to your account.

Insurance Guidelines

If you have dental insurance, we will submit the initial claim forms and supporting documentation as a courtesy service. If an insurance company fails to honor our request for payment within 60 days of filing, you will be billed the balance of the account. You will then need to seek reimbursement directly from your insurance company.

We are not a Preferred Provider of any insurance company plan. Our patients and their insurance companies have a legal agreement and our office is not involved in that agreement. Our relationship is with our patients only. Determination of your dental needs is based solely on the best treatment for your oral health and will not be based on treatments your insurance company will reimburse.

We make every effort to remain current with our patient's insurance plans and benefits. However, since our office has no direct affiliation with any insurance provider, we cannot guarantee if or how much insurance will pay, or the accuracy of our estimation of your insurance benefits. For the most accurate information regarding insurance benefits, please contact your insurance provider. At your request, we will submit a pre-estimate to your insurance company before any major work (i.e. crowns, bridges, and partial dentures) is initiated.

Please remember, dental insurance plans are designed to ***share*** in the cost of most dental treatments. Therefore, many dental procedure fees will require partial payment directly from you.

Lockheed Martin Delta Dental of California insurance holders:

If you have insurance through Delta Dental of California with Lockheed Martin, you will be required to pay in full at the time of service. Our office will file your claim as usual, but Delta Dental will reimburse you directly. Lockheed Martin's agreement with Delta Dental of California stipulates that insurance benefits be sent directly to the policy holder. Please direct any questions regarding this restriction to Lockheed Martin and Delta Dental of California.

We accept cash, personal checks, MasterCard, Visa, and Discover.

WE DO NOT ACCEPT ANY HMO'S, DMO'S, OR DISCOUNT DENTAL PLANS.

An insurance plan must allow you to see any dentist (out-of-network doctor) that you select.

I have read, understand, and agree to the above policy concerning payment and insurance coverage.

_____

Signature of patient or legal guardian

Consent for Dental Treatment

Please read the following information carefully.

I authorize Gary L. White, D.D.S., his associates, dental hygienists and assistants and designated staff (collectively, "Dr. White") as allowable by law, to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. White to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize Dr. White to perform all recommended treatment mutually agreed upon by me and to involve specialists as needed to provide proper care.

As with all health care procedures, I understand that dental treatment involves risks. I understand that due to these risks, additional treatment may be necessary in some circumstances. Listed below are risks associated with treatments performed by Dr. White and his staff.

Cleanings:

I understand that cleanings can temporarily cause sore gums and sensitive teeth.

Fillings:

I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I understand that teeth can be sensitive after a filling. I realize that fillings are rarely "permanent" and usually require periodic replacement.

Crowns and Bridges:

I understand that crown and bridges are performed on teeth that are often severely compromised. Therefore, complications with these teeth may arise necessitating root canal therapy or extraction. I understand that it is sometimes not possible to exactly match the color of natural teeth with artificial teeth. I further understand that I may be wearing temporary crowns that are prone to loosening and may need recementing. I will immediately notify Dr. White of that occurrence so that a temporary restoration is maintained until the final restoration is delivered. I realize that any changes I may desire in color, shape, size, etc. of a crown must be made prior to final fabrication of the restoration. I understand and agree that it is my responsibility to return within one month of tooth preparation for final cementation of the restoration.

Periodontal Cleaning:

Periodontal disease can be a serious condition, causing gum inflammation and/or bone loss and may lead to loss of permanent teeth. I understand that periodontal cleanings (scaling and root planning ("SCRP")) is a deep cleaning under the gum tissues which can cause sensitive teeth and sore gums. SCRP may be augmented with antibiotic placement under the gums. Even with deep cleanings, selective extraction of teeth and tooth replacement may still be necessary if teeth and gums do not respond to treatment. I understand that much of the success of periodontal treatment depends on my continuing home care and faithful adherence to following my doctor's instruction, including strict observance of recall appointments. I understand that care by a specialist may be necessary if extensive periodontal therapy is needed.

Local Anesthetics:

I understand local anesthetics will be used in most dental treatments. I further understand that soreness at the injection site, temporary rise in heart rate, allergic reactions, and swelling are possible complications with the use of local anesthetics. I understand that I should not eat while numb due to the risk of biting my lips, cheeks, or tongue and causing serious injury.

Drugs and Medications:

I understand that antibiotics, analgesics, and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

No Treatment:

I understand a treatment option is to receive no treatment. I also understand that I have a right to refuse any treatment Dr. White recommends by signing a separate refusal of treatment consent form consisting of risks of no treatment. I further understand that unwillingness to sign a refusal of treatment form or refusal of multiple recommended treatments could lead to dismissal from Dr. White's care.

I understand that during the course of treatment, conditions not evident during examination may necessitate procedures different from those planned and may need a specialist for necessary treatment. I understand that I will be notified of any necessary treatment changes as well as cost differences. I understand any costs incurred from a specialist are my responsibility.

I understand that Dr. White does not perform root canals, fabricate complete dentures, treat severe periodontal disease, or treat major TMJ disorders and would refer me to a specialist for these treatments.

I understand that surgical dental treatments, such as tooth extractions and gum surgery, will be preceded by a separate consent form.

I understand that dental hygienists, dental assistants and other dentists may administer different aspects of care as allowed by law.

I understand that pictures of my face, teeth, and smile may be taken for my treatment and my record. Close-up pictures of my teeth may be used for patient education purposes. Any pictures that reveal my identity, such as full face pictures, will be preceded by a separate consent for use beyond my treatment record.

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plans and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment.

CONSENT: I certify that I understand English and have carefully read the information above. My signature below signifies that I understand the above treatments together with the known risks and complications associated with each treatment. I hereby give my consent for routine dental treatment by Dr. White.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctor's Signature Date

_____

Witness' Signature Date

Gary L. White, D.D.S., P.A.
3701 Hulen Street, Suite A
Fort Worth, TX 76107
(817) 731-2124

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

  We may also create and distribute de-identified health information by removing all references to individually identifiable information.

  We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

  Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Gary L. White, D.D.S.
3701 Hulen Street
Suite A
Fort Worth, TX 76107
(817) 731-2124

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Gary L. White, D.D.S., P.A.
3701 Hulen Street, Suite A
Fort Worth, TX 76107
(817) 731-2124

HIPAA Acknowledgement Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that Dr. White may use my protected health information for the following reasons only:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and dentist certifications

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that at any time, I may request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I am not required to sign this form to obtain dental treatment. My signature is simply an acknowledgement that I have been given this form by the office of Gary L. White, D.D.S., and that I have read this form regarding protection of my health information.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____