PATIENT INFORMATION

NAME (FIRST, LAST) ____

ADDRESS ____

CITY _________________________ STATE __________ ZIP ____________

BIRTHDATE _____________________ WORK PHONE __________________

CELL PHONE _____________________ HOME PHONE ___________________

E-Mail ______________________________ MALE FEMALE

MINOR SINGLE MARRIED DIVORCED WIDOWED SEPERATED

HOW DID YOU HEAR ABOUT US? ___________________________________

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _______________________

RELATIONSHIP TO PATIENT ______________________ BIRTHDATE _______________________

ADDRESS (IF DIFFERENT FROM THE PATIENT) ____

CITY ______________________________ STATE ______________ ZIP ________________

SS NUMBER _______________________ EMAIL ____

CELL PHONE _________________________ HOME PHONE ________________________________

NAME OF INSURED ________________________ RELATIONSHIP TO PATIENT ________________

EMPLOYER/GROUP NAME ____________________ GROUP NUMBER _______________________

INSURANCE COMPANY ___________________________ PHONE _________________________

ADDRESS ____

CITY ___________________________ STATE _______________ ZIP ________

ADDITIONAL INSURANCE

NAME OF INSURED ________________________ RELATIONSHIP TO PATIENT ________________

SS NUMBER _____________________________ BIRTHDATE ______________________________

EMPLOYER/GROUP NAME ____________________ GROUP NUMBER _______________________

INSURANCE COMPANY ___________________________ PHONE _________________________

ADDRESS ____

CITY ___________________________ STATE _______________ ZIP ________

PATIENT MEDICAL HISTORY

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES NO DATE OF LAST EXAM: ____________________

PHYSICIAN'S NAME AND PHONE NUMBER: ____

HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS? YES NO

HAVE YOU HAD ANY MAJOR SURGERIES/OPEARATIONS? NO YES IF YES PLEASE EXPLAIN:

____

DO YOU USE TOBACCO? YES NO

DO YOU CONSUME ALCOHOL? YES NO

HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

DO YOU HAVE ANY ALLERGIES? NO YES → TO WHAT? ____

DO YOU TAKE ANY OVER THE COUNTER OR PERSCIPTION MEDICATIONS? NO YES → PLEASE LIST CURRENT MEDICATIONS: ____

PREFERRED PHARMACY NAME AND NUMBER ____

WOMEN ONLY- ARE YOU PREGNANT? YES NO NURSING? YES NO ON BIRTH CONTROL? YES NO

CHECK IF THE PATIENT HAS/HAD:

- ☐ AIDS/HIV
- ☐ ALLERGIC TO ASPRIN
- ☐ ALLERGICE TO PENICILLIN
- ☐ ALLERGIES
- ☐ ANEMIA
- ☐ ANGINA
- ☐ ARTIFICIAL HEART VALVES
- ☐ ARTIFICIAL JOINTS
- ☐ ASTHMA
- ☐ BLOOD DISEASE, CLOTTING DISORDERS
- ☐ BLOOD TRANSFUSION
- ☐ CANCER
- ☐ CHEST PAINS
- ☐ CIRCULATORY PROBLEMS
- ☐ COUGH, PERSISTENT OR BLOODY
- ☐ DIABETES
- ☐ EMPHYSEMA
- ☐ EPILEPSY/CONVULSIONS
- ☐ FAINTING/SEIZURES
- ☐ GLAUCOMA
- ☐ HEADACHES
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEPATITIS
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ KIDNEY DISEASE
- ☐ LEUKEMIA
- ☐ LIVER DISEASE
- ☐ LOW BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ OSTEOPENIA
- ☐ OSTEOPOROSIS
- ☐ PACEMAKER
- ☐ RADIATION THERAPY
- ☐ RESPIRATORY DISEASE
- ☐ RHEUMATIC FEVER
- ☐ SCARLET FEVER
- ☐ SHORT OF BREATH
- ☐ SICKLE CELL ANEMIA
- ☐ SINUS TROUBLE
- ☐ SNORE/SLEEP APNEA
- ☐ STD'S
- ☐ STROKE
- ☐ SWELLING OF FEET/ANKLES
- ☐ TAKING BLOOD THINNER
- ☐ THYROID PROBLEMS
- ☐ TUBERCULOSIS
- ☐ TUMOR OR GROWTH ON HEAD/NECK
- ☐ ULCER
- ☐ WEIGHT LOSS UNEXPLAINED

OTHER:

____

____

PATIENT DENTAL HISTORY

1. WHEN WAS YOUR LAST DENTAL VISIT? ___________________________
2. HOW MANY TIMES A DAY DO YOU BRUSH YOUR TEETH? __________________________________
3. DO YOU USE A MANUAL BRUSH OR ELECTRIC? ____
4. HOW OFTEN DO YOU FLOSS? ____
5. IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHAT WOULD THAT BE?
   ____
6. YES NO DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?
7. YES NO ARE YOUR TEETH SENSITIVE TO HOT, COLD, OR SWEETS?
8. YES NO ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?
9. YES NO DO YOU FEEL PAIN IN ANY OF YOUR TEETH?
10. YES NO DO YOU HAVE ANY SORES OR LUMPS IN YOUR MOUTH?
11. YES NO HAVE YOU EVER SUFFERED TRAUMA TO YOUR FACE MOUTH OR JAW?
12. YES NO DOES YOUR JAW EVER CLICK, POP, CRACKLE OR ACHE?
13. YES NO DO YOU HAVE PAIN IN YOUR JAW JOINT, EAR OR SIDE OF THE FACE?
14. YES NO DO YOU HAVE DIFFICULTY OPENING OR CLOSING YOUR MOUTH?
15. YES NO DO YOU HAVE DIFFICULTY CHEWING?
16. YES NO DO YOU HAVE FREQUENT HEADACHES?
17. YES NO DO YOU CLENCH OR GRIND YOUR TEETH?
18. YES NO DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?
19. YES NO HAVE YOU PROBLEMS WITH PREVIOUS DENTAL WORK?
20. YES NO HAVE YOU EVER HAD BRACES?
21. YES NO DO YOU USE ANY TYPE OF MOUTH RINSE?
22. ARE YOU INTERESED IN
    - ☐ WHITENING
    - ☐ INVISIBLE ALIGNERS
    - ☐ VENEERS

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health.

Signature of Patient, Guardian, or Legal Representative ____

Printed Name of Patient, Guardian, or Legal Representative _____________________________________

Date: _________________________

ICE BREAKER

We want to get to know you. We are going to ask you a few questions and asked Dr. Hegazin to answer them too. Let's compare!!

What is your favorite restaurant?

Dr. Hegazin's Answer:
"Texas Road House!"

Where would your dream vacation be?

Dr. Hegazin's Answer:
Santorini Islands, Greece

What is your favorite sports team?

Dr. Hegazin's Answer:
Bayern Munich-Germany Soccer Team

CONSENT FORM

HIPAA CONSENT POLICY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice can be read at the following link. Notice of Privacy Practices We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will update the revised Notice of Privacy Practices on our website and you may view it at any time which will contain the changes. Those changes will be effective from the date the notice is revised and issued on the website and may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Address: 7650 Stacy Rd., Ste. 240, McKinney, TX 75070
Telephone: 214-592-0441

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- *FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.* For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.
- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
  We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA, MasterCard, Discover and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 48-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $50 cancellation fee will be assessed for the first individual and $25 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm your appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- Treatment appointments made that **exceed $500.00 will require 50% down** to hold the appointed time, and 100% down for Saturday appointments.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Signature of Patient, Parent or Guardian____________________________ Date: _____________________

Marble Dental Care Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (214) 592-0441.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Marble Dental Care does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your*

Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Marble Dental Care maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Marble Dental Care.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Marble Dental Care occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I have reviewed Marble Dental Care's Privacy Policy.

Print Name ______________________________ Signed ____________________________________ Date_____________________