Thomas Campbell Bourland, DDS
White Rock Oral & Maxillofacial Surgery
1151 N. Buckner Blvd. Ste. 406
Dallas, TX 75218
Phone: 214-328-6354 Fax: 214-327-7088
Email: whiterock@nedoms.com

PERSONAL AND CONFIDENTIAL INFORMATION (PLEASE PRINT IN BLACK OR BLUE INK)

Date_____

Patient Information

Patient Name_____ Age_____ Sex_____
Birthdate_____ Social Security # _____ Driver License # _____
Address_____ City_____ State_____ Zip Code_____ Apt#_____
Home Phone_____ Cell Phone_____ Email _____
Employer_____ Business Phone_____ Ext. _____
Dentist _____ Physician _____
Referred By _____ Present Complaint _____
Is anyone with you today? If yes, who? _____ Relationship_____
Have you been a patient here before? _____ If yes, when? _____
Have any friends/family been treated by us? _____ If yes, who? _____

Responsible Party (if other than patient)

Parent/Spouse Name_____ Age_____
Birthdate_____ Social Security # _____ Driver License # _____
Address_____ City_____ State_____ Zip Code_____ Apt#_____
Home Phone_____ Cell Phone_____ Email _____
Employer_____ Business Phone_____ Ext. _____

Primary Dental Insurance Information

Policy Holder _____ Birthdate _____ Social Security # _____
Patient Relationship to Insured: _____Self _____Spouse _____Child _____Other
Insurance Company _____ Employer_____
Member ID # _____ Group # _____ Phone # _____

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MEDICAL HISTORY (PLEASE READ AND ANSWER CAREFULLY)

Do you use any form of tobacco products? (Smoke/Dip)	Yes_____ No_____
Are you allergic to any medications?	Yes_____ No_____
Are you allergic to penicillin?	Yes_____ No_____
Are you taking Aspirin/blood thinner?	Yes_____ No_____
Are you taking any medications now?	Yes_____ No_____
Are you taking oral contraceptives?	Yes_____ No_____
Are you pregnant?	Yes_____ No_____
Are you a "gagger"?	Yes_____ No_____
Are you under the care of a physician now?	Yes_____ No_____
Have you ever been admitted to the hospital?	Yes_____ No_____
Have you ever had problems under general anesthesia?	Yes_____ No_____

List the medications you are **allergic** to:_____

List the medications you are **currently** taking:_____

List any past surgeries you have had: _____

HEIGHT:_____ WEIGHT:_____

PLEASE CIRCLE ANY OF THE FOLLOWING IN WHICH YOU HAVE OR HAVE HAD:

BP:_____
HR:_____

Heart Trouble	Shortness of Breath	Bleeding Problems
Heart Murmur	Difficulty Breathing	Nervous Problems
Rheumatic Fever	Lung Trouble	Thyroid Problems
High or Low Blood Pressure	Asthma	Peptic/Stomach Ulcers
Anemia	Liver Trouble	Problems with Tooth Extractions
Epilepsy	Kidney Trouble	Hip/Knee Replacement
Sexually Transmitted Diseases	Glaucoma	History of Bisphosphonate use
Communicable Disease Process	Diabetes	Cancer/Radiation of Head or Neck

FINANCIAL ARRANGEMENTS

All fees are due at the time services are rendered.

Cash_____ **Check**_____ **Charge**_____ **Insurance** (name of carrier) _____

I hereby certify that I have answered the above questions correctly and will not hold my doctor, or any other member of his staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature (parent/guardian if patient is a minor)_____

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AUTHORIZATION FOR RELEASE OF MEDICAL AND DENTAL INFORMATION

Not infrequently are we asked to provide information related to your care or to your primary care physician and/or to your insurance carrier to resolve issues related to charges. Spouses, family and/or children frequently request to make or change appointments, request copies of records and any other pertinent information. **Without your authorization we CANNOT provide such basic information to anyone except you, the patient.** This simple form is to allow you to provide that authorization, or to specifically deny such authorization when appropriate. I understand that information released is for the sole purpose of providing quality continued patient care. I further understand that I may revoke this consent, in writing, at any time. **PLEASE CHECK ANY/ALL THAT YOU SPECIFICALLY WISH TO INCLUDE.**

I hereby authorize the release of information from my medical/dental record to the following:

_____**Primary Care Physician**- Please list name and phone number

1. _____
2. _____

_____**Primary Dentist**- Please list name and phone number

1. _____
2. _____

_____**Spouse/Partner**- Please list name and phone number

1. _____
2. _____

_____**Children/Siblings/Family Members**- Please list name and phone number

1. _____
2. _____
3. _____
4. _____

_____**Insurance Carrier-** Please list name and phone number

1. _____
2. _____

May we leave medical/dental information on your voicemail or answering machine if we are unable to reach you? If yes, Home Number:_____ Mobile Number:_____

Patient Signature (parent/guardian if patient is a minor)_____

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I am requesting your consent to have one of my staff take the following prior to my examination:

1. Diagnostic radiograph (if necessary)

2. Blood Pressure

_____ _____

Thomas Campbell Bourland, DDS Date

_____ _____

Signature of Patient or Legal Guardian Date

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FINANCIAL POLICY

Thank you for choosing White Rock Oral & Maxillofacial Surgery. We are committed to providing the best care for our patients and making your experience with our office a positive one.

Payment Policy: We ask that you read through the financial policy and sign at the bottom prior to treatment. **Full payment is due at the time services are rendered unless prior arrangements have been made with our office. We accept CASH, CHECKS from local banks, or CREDIT CARDS. Any balance that we submit to your insurance carrier is due to us, by you, if we have not received payment from your insurance carrier within 90 days from the date the services were rendered.**

We can also give you information about Care Credit, a patient financial plan.

There is a $12.00 fee charged for checks returned due to insufficient funds. You are responsible for any fees incurred in obtaining any unpaid balances which may include billing, collections or attorney fees.

Regarding Insurance: We participate with a number of dental insurance plans that we will contact to verify eligibility and benefits to strive to do so as accurately as possible, however you are encouraged to call your insurance to obtain benefit information. Some services may **not be covered by your dental insurance carrier** such as exams and radiographs (due to frequency limitations) or anesthesia depending on how your contract is written and you will be responsible for any out of pocket expenses at the time services are rendered. We will submit to most insurance plans as a courtesy to you and if we **do not participate with you dental insurance plan, payment may be sent directly to you.** Your insurance policy is a contract between you, your employer and the insurance company; we are not a party to that contract, and do not have the power to make the insurance company remit payment. You are responsible for providing the office necessary information concerning your insurance. If accurate information is not provided, this can delay payment – *regardless of benefits or coverage you are responsible for any amount unpaid by your insurance within 90 days from the date the services were rendered.*

Medicare/Medicaid Beneficiary's: We **are legally opted out** of Medicare/Medicaid and therefore you are responsible for the balance in full. Because we are legally opted out of Medicare, we or you are not able to submit the claim to Medicare. Medicare/Medicaid is usually primary and all other secondary insurances will not be billed thru our office.

Missed Appointments: We require that you give our office 48 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If

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you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $50.00 will be charged to you**; this fee cannot be billed to your insurance company and will be your direct responsibility. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $50.00 cancellation fee will be charged. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

Minor Patients: Parents or Guardians are responsible for all charges for minor children.

Please let us know if you have any questions regarding our Financial Policy.

X_____ **X**_____

Signature of person financially responsible Please print full name

_____

Date

NOTICE OF PRIVACY PRACTICES FOR WHITEROCK ORAL SURGERY

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 took effect in 2010, 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 the treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to obtain and provide information from specialists and other healthcare providers for services we provide 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 was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the 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 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 to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in all owing 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 military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize 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 of protected health information of inmate or patient 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 $10.00 for duplication of paperwork and $15.00 for duplication of radiographs. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. 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. 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 our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative mean 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 e-mail, you are entitled to receive this Notice in written form.

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 you disagree with a decision we made about access to your health information or in response to a request you made to amend your 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.