WELCOME TO CYPRESS ROSEHILL FAMILY DENTISTRY

PATIENT INFORMATION

(Please print in legible writing)

Patient's Name: Dr /Mr / Mrs / Ms_____
First Middle Last

Preferred Name (Nickname):_____

Address: _____
Street Apt/Unit/Trl/Suite # City/State/Zip Code

Primary Phone #: _____ Alternative Phone #: _____

Date of Birth: _____ Social Security # (if patient is over 18): _____

E-mail: _____

Patient Employed By: _____ Occupation: _____
(***Parent's employer and occupation if patient is a minor)***

How did you hear about us? _____

Who should we notify in case of an emergency?

Name: _____ Phone: _____ Relationship: _____

FOR MINORS ONLY
Who is financially responsible for this patient if under 18? _____
(Full name of person responsible for account)

DOB: _____SSN:_____Relationship:_____

INSURANCE

Insurance Company:_____ Insured's Name:_____

Telephone:_____ Date of birth:_____

ID No. or SSN:_____ Relationship to patient:_____

AUTHORIZATION

**** Even if you don't currently have dental insurance, please review the following policy because you may in the future. Thank you.***

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature: _____ ***Date:*** _____

MEDICAL HISTORY

(All information is completely confidential)

1. Do you have any of the following? **(Please Circle)**

ADHD	Dementia	Pregnancy
Anemia	Diabetes =Type: 1 2	Prolonged Bleeding
Arthritis, Rheumatism	Epilepsy	Respiratory Disease
Artificial Heart Valves	Heart Murmur	Rheumatic Fever
Artificial Joints	Heart Problems	Sickle Cell Disease
Autoimmune Disorder	Hemophilia= Type:_____	Shortness of Breath
Asthma	Hepatitis= Type: A B C	Skin Rash
Autism	High Blood Pressure	Stroke
Blood Disease(Details below)	HIV +/ A.I.D.S.	Tobacco= Type: Chew Smoke
Details:_____		#_____ Packs/day
Cancer/Tumor	Jaw Pain	Thyroid Problem(circle below)
Cholesterol	Kidney Disease	Type: Hypo Hyper
Chemical Dependency	Liver Disease	Tuberculosis
Circulation Problems	Mitral Valve Prolapse	Vape
Dental Anxiety	Pacemaker	Venereal Disease

2. ***FOR WOMEN ONLY***: Are you currently pregnant or believe you maybe? Yes / No Time Length:___

3. Do you have any disease or condition not listed above or any major surgeries? **Yes / No**
   If yes, please describe: _____

   _____

4. Please list any medications along with the dosage and reason you are currently taking or have taken within the last six months:

   _____
   _____
   _____
   _____

5. Do you have any allergies to any drug or medication? **Yes / No** If yes, please list:

   _____

6. What is your main goal for your oral health (ex. health gums, white teeth, straight teeth, etc?

   _____

7. How many times do you brush a day? ____ times (morning/night)
   How many times do you floss? ____ times/ (day/week)(Y/N)

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, the doctor has my permission to ask the respective healthcare provider or agency who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature: _____ **Date:**_____

GENERAL CONSENT

I hereby authorize Dr. Tung Huynh or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis.
If diagnostic models/casts are made, they will be kept for 6 months, after which they will be disposed. If you would like to have your diagnostic casts please let us know.
Upon such diagnosis, I consent for Dr. Tung Huynh or acting provider to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. There is no guarantee as to the long term success of treatment-even under ideal conditions or circumstances. Any treatment can fail due to other factors beyond the doctors' control. I understand that a perfect result is not and cannot be guaranteed or warranted.

By Texas law, all original records, x-rays and models belong to the dentist. If you desire duplicate copies, please allow our office at least 72 hours. There is a fee depending on the amount of material to be duplicated.

I agree to the use of anesthetics and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Patient/Guardian Signature: _____ ***Date:*** _____

OFFICE POLICY

WE ASK THAT YOU READ THE REMAINING SECTION THOROUGHLY AND ASK QUESTIONS IF MORE INFORMATION IS NEEDED.

Conduct Policy

- To protect the privacy of our patients, only the patient receiving treatment will be allowed in the treatment room with the exception of minor patients. **We allow one guardian per child in the treatment room.**

- **All minors must be accompanied by an adult at all times.** Minors are not allowed through the operatory unless permission is granted. It is unsafe to allow children access to the operatory and nearby vicinity due to the nature of the medical environment.

Confirmation Policy

We will send a text message ***2+ days prior*** to your appointment date. It is the patient's responsibility to update the office with any personal information and method of contact

necessary to confirm your scheduled appointment. If confirmation is not received within 24 hours, please be aware that this may result in delay of appointment time. **Failure to confirm scheduled appointments may and/or will result in cancellation.**

Appointment Time

1)Please arrive on time for your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly to their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day**. If you are 15 minutes late to your appointment, it may be subject to cancellation.** Our practice is firm in this regard to our office policy.
2)We respect our patients' time and strive to remain on schedule. Some visits may be more complex than anticipated and emergencies may arise that could delay us. Every effort will be made to notify you beforehand so you may choose to come later or reschedule.

At the time an appointment is made, a deposit will be required. The deposit will serve as a reservation for your appointment time and will be credited towards your treatment. This deposit will become non-refundable if you fail to abide by the cancellation policy. You may call in your appointment deposit and make your payment over the phone if that is convenient.

No appointment time will be guaranteed if the deposit is not made at the same time when the appointment is made.

Cancellation Policy

- Cancellation/Rescheduling/No Show: **The patient must notify the office 48 hours prior to appointment time made.** If not made prior to 48 hours a cancellation fee will apply.
- The deposit fee will not apply to Medicaid/Medicare patients, **however all other rules in the cancellation policy will apply.**
- Failure to cancel/reschedule within 48 hours or No show at the appointment time will result in the following:

    - **First missed appointment a cancellation fee will apply. (The amount will depend on the time and/or procedure for the appointment.)**
    - **After one missed appointment, 2nd appointment will require a $100 or more deposit**, if the appointment is missed/canceled/no show or if a patient is 15 minutes late, **the $100 deposit will be nonrefundable and will be applied as a cancellation fee.**
- **If three appointments are missed**, you will no longer be allowed to schedule for treatment and can only be seen as a walk-in patient.
- **Patients who chronically cancel/reschedule/no show 3 appointments or more will be dismissed from the practice.**

- **There will be no exceptions**. Time lost due to missed appointments cannot be recovered and we are not given the opportunity to reschedule that time with another patient who has true dental needs.
- As a courtesy we will give you a reminder text 2+ days prior to your appointment; however it is your responsibility to keep the appointment time that you requested.

Patient Financial Responsibility

FULL PAYMENT IS DUE AT TIME OF CHECK-IN FOR THE APPOINTMENT. WE ACCEPT CASH, ALL MAJOR CREDIT CARDS, AND DEBIT CARDS. WE ALSO OFFER 0% INTEREST FINANCING WITH CARE CREDIT WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL. ALL PAYMENTS ARE DUE AT TIME SERVICES ARE RENDERED UNLESS A PAYMENT PLAN HAS BEEN ARRANGED AND APPROVED.

INSURANCE

We accept most major PPO dental insurance. We are not contracted with HMO therefore we will not be able to get access to your plan.

- As a courtesy to our patients, our office will accept your insurance benefits on assignment ***provided that benefits have been verified prior to your visit.*** The patient is responsible for all charges incurred including those for services not covered or denied by the patient's insurance company. We ask that you carefully review the contract and fees given to you by your insurance.
- Please provide our office with all necessary information concerning your insurance as well as all pertinent information about you and/or the insured. Otherwise, you may not be able to use your benefits at the time of treatment or services rendered.
- We will charge co-payments based upon our office fees and the breakdown of insurance coverage**.**
- **Please be aware that any benefits quoted by your insurance company are only an estimate and not a guarantee of benefits. When all payments have been received and accounted for, we will refund the patient any overpayment and, likewise, will bill you for any balance outstanding.**
- We are not responsible for denied or reduced insurance payments. Any discrepancy of amounts paid or not paid by your insurance company must be resolved between you and the insurance company. You are responsible for the total charge of services rendered. Your insurance is a contract between you and your insurance company, we are not party to that contract. If your insurance company has not paid your account in full within 45 business days, the balance will be the patient's responsibility. If you have multiple insurances, we will allow 60 days for your insurance company to pay in full, if the amount is not paid, the patient will be responsible for the full amount. Please be aware that some or possibly all services may not be considered reasonable, usual, or customary under the terms of your dental and/or medical policy. It is your responsibility to know the contract terms between you and your dental/medical insurance company.

Usual and Customary Rates

You are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out **prior** to your appointment time.

Minor patients

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash at the time service has been verified.

Billing

Please update any patient contact information necessary. It is your responsibility to inform the office of any contact update. Our office will send out statements/communication by mail based upon the contact information provided.

Any balance younger than 60 days will be charged a $20 late fee if not paid by the payment deadline. Balances which are 60 days old or older will incur a monthly 1.5% finance charge which equals an 18% annum rate. There will be a $20 fee for declined credit card transactions. There will be a $25 fee per day for late payments.

Refund

Refunds for overpayment will be given to the account guarantor after all treatment is completed and insurance has been collected via check. Please allow a 24 hrs window for the check to be processed.

Credit Cards/ Carecredit Payments

All payments greater than $200 will automatically acquire a % fee depending on the amount and the program/promotion being used. All cash and debit card transactions will not have any additional fees.

Collections

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsibility party for the reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

An account with a past due balance may not schedule for any new treatment unless it is a true medical emergency. All balances must be paid off in order to start new treatment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere with the help of your cooperation.

I have read, understand, and agree to abide by the Cypress Rosehill Family Dentistry policies outlined herein. The office policy states the patient's responsibility regarding conduct, appointment time, cancellation, and patient financial responsibility. ***In the event that I do not abide by the policies outlined herein or display any form of inappropriate behavior towards the practice, staff members, other patients or causes damages to the practice, I understand that my patient-physician relationship may be terminated and I will be dismissed from the practice permanently.***

Signature: _____ **Date:** _____

(Patient/Parent or Guardian)

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

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 our Notice of Privacy Practices before you decide whether or not 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, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. 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 issue a revised Notice of Privacy Practices, which will contain the changes. Those changes 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 the office at (281)310-5345.

Right to Revoke:

You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been given the opportunity to review a copy of Cypress Rosehill Family Dentistry's Notice of Privacy Practices.

Signature (Patient or Patient's Representative):

X_____

Date:_____