POLISH
dentistry

514-A Elgin
Houston, TX 77006
o: (713)942-0101
f: (713)942-7014

PATIENT REGISTRATION

Patient Information:

First Name: _____ Last Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ **How did you hear about us?** : Mailer Google Magazine Patient

Other _____

Email: _____ I would like to receive email correspondences: YES / NO

Social Security: _____ D.O.B: _____ DL#: _____

Emergency Contact: _____ Phone: _____

Sex: M or F Marital Status: single married divorced separated widowed partnered

Primary Insurance Information:

Name of Insured: _____ Relationship to Patient: _____

Insured's Employer: _____ Employer Phone: _____

Insurance Company: _____ Insurance Phone: _____

Please carefully read below:

I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE POLISHDENTISTRY TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND POLISHDENTISTRY, AND **THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE**. I ALSO ASSIGN ALL INSURANCE BENEFITS TO POLISHDENTISTRY AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

_____ _____

Patient Signature Date

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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 medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? Yes No If yes, please explain _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain_____

Have you ever had a serious head or neck injury? Yes No If yes, please explain_____

Are you taking any medications, pills or drugs? Yes No If yes, please explain_____

Do you take or have you taken Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Do you snore? Yes No

Have you been diagnosed with sleep apnea? Yes No

Women:
Taking oral contraceptives?
Pregnant/Trying to get pregnant? Nursing?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other _____

Do you have or have you had any of the following?

AIDS/HIV Positive	**Chest Pains**	**Frequent Headaches**	**Irregular Heartbeat**	**Scarlet Fever**	**High Cholesterol**
Alzheimer's disease	**Cold Sores/Fever Blisters**	**Genital Herpes**	**Kidney Problems**	**Shingles**	**Osteoporosis**
Anaphylaxis	**Congenital Heart Disorder**	**Glaucoma**	**Leukemia**	**Sickle Cell Disease**	
Anemia	**Convulsions**	**Hay Fever**	**Liver Disease**	**Sinus Trouble**	
Angina	**Cortisone Medicine**	**Heart Attack/Failure**	**Low Blood Pressure**	**Spina Bifida**	
Arthritis/Gout	**Diabetes**	**Heart Murmur**	**Lung Disease**	**Stomach/Intestinal Disease**	
Artificial Heart Valve	**Drug Addiction**	**Heart Pace Maker**	**Mitral Valve Prolapse**	**Stroke**	
Artificial Joint	**Easily Winded**	**Heart Trouble/Disease**	**Pain in Jaw Joints**	**Swelling of Limbs**	
Asthma	**Emphysema**	**Hemophilia**	**Parathyroid Disease**	**Thyroid Disease**	
Blood Disease	**Epilepsy or Seizures**	**Hepatitis A**	**Psychiatric Care**	**Tonsillitis**	
Blood Transfusion	**Excessive Bleeding**	**Hepatitis B or C**	**Radiation Treatments**	**Tuberculosis**	
Breathing Problem	**Excessive Thirst**	**Herpes**	**Recent Weight Loss**	**Tumors or Growths**	
Bruise Easily	**Fainting Spells/Dizziness**	**High Blood Pressure**	**Renal Dialysis**	**Ulcers**	
Cancer	**Frequent Cough**	**Hives or Rash**	**Rheumatic Fever**	**Venereal Disease**	
Chemotherapy	**Frequent Diarrhea**	**Hypoglycemia**	**Rheumatism**	**Yellow Jaundic**	

Have you ever had any serious illness not listed above? Yes No If yes, please explain_____

Comments_____
_____
_____
_____
_____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ _____DATE _____

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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 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. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare 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.
- Healthcare 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, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

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 to 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 a paper copy of this notice from us upon request.

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 October 17, 2002 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.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following persons_____

☐ I authorize the EMAIL AND PHONE NUMBER listed below to be used to leave personal health information on, if I am unable to speak directly with office:

I have read and understand the above information.

_____
Patient Signature Date

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polishDENTISTRY BILLING PROCESS

Thank you for choosing polishDENTISTRY. In efforts to better serve you, we would like to take the time to explain the billing process at our office.

Once you provide the office with your dental insurance, as a courtesy to you , we call your insurance company and verify your benefits. **THE INFORMATION WE RECEIVE FROM YOUR INSURANCE COMPANY IS ONLY AN ESTIMATION OF COVERAGE AND NOT A GUARANTEE.** After you have been seen in our office, we will file your claim to the insurance company directly. **If the insurance company does not cover the estimated amount in full, you will receive a phone call/ statement in the mail and will be responsible for the remaining account balance, which is to be paid within 30 days.**

Thank you again for choosing polishDENTISTRY for your dental needs. We look forward to a long lasting relationship with you.

I have read and understand the billing process at polishDENTISTRY.

_____ _____

Patient's Name (Printed) Patient's Signature & Date Signed

PRACTICE POLICIES

Our goal is to provide quality dental care in a timely manner. And we value all of our patient's own time. In order to do this we have to implement a cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT
In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you **call 24 hours in advance if cancelling, or it will be considered a NO SHOW and fees will be assessed.**

NO SHOW POLICY
A "no show" is an appointment that was not canceled with 24 hours notice. These missed appointments inconvenience other patients who need dental care and the office's schedule. A no show for a scheduled appointment will result in a fee of **$50 for every half hour scheduled**. (We understand emergencies do happen so as a courtesy, your first no show will have no penalty.)

LATE ARRIVALS
In an effort to serve our patients in a timely manner, we ask that you be on time for your scheduled appointment. In the event you are running late, please call the office. If you are **more than 8 minutes late** to your scheduled appointment, you may be asked to reschedule.

CELL PHONE POLICY
As a courtesy to other patients and to our doctors, and in an effort to maintain our schedule, we request that **cell phones be put away while the doctor, hygienist, or assistant is in the room with you.** In order to protect patient and staff privacy, we do not allow unauthorized recording of any kind in our office.

I have read and understand the "Practice Policies".

_____ _____

Patient's Name (Printed) Patient's Signature & Date Signed

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BOOST IN-OFFICE TEETH WHITENING INFORMED CONSENT FORM

This information has been given to me so that I can make an informed decision about having my teeth whitened. I may take as much time as I wish to make my decision about signing this informed consent form and I have been advised that I may consult legal counsel should I wish. I have the right to ask questions about any procedure before agreeing to undergo the procedure. My dentist has informed me that my teeth are discolored, and could be treated by in-office whitening (also known as "bleaching") of my teeth. I understand that polishDENTISTRY (and its respective subsidiaries) provides "free teeth whitening " after new patient exam, x-rays and cleaning are completed. It is performed using Opalescence "Boost" whitening treatment.

DESCRIPTION OF THE PROCEDURE

Opalescence Boost in-office tooth whitening is a procedure designed to lighten the color of my teeth using a hydrogen peroxide gel. During the procedure, the whitening gel will be applied to my teeth, and a plastic retractor will be placed in my mouth to help keep it open. The soft tissues of my mouth (gum tissue) will be covered by a light cured resin barrier to ensure they are not exposed to the whitening gel. After the treatment is completed, the retractor and all gel and tissue coverings will be removed from my mouth. Before and after the treatment, the shade of my upper-front teeth will be assessed and recorded. **I understand that the results of my *Boost* Treatment cannot be guaranteed, and may vary from patient-to-patient.** Some patients' teeth whiten more than others, or see the effects to a greater degree.

ALTERNATIVE TREATMENTS
I understand I may decide not to have the ***Boost*** treatment at all. I understand there are alternative treatments for whitening my teeth for which my dentist can provide me additional information, BUT some fees may be applied. These treatments also help with at-home maintenance, and we encourage their use after the Boost session. These treatments include:

Whitening Toothpastes
Whitening Gels applied into customized bleaching trays
Take-Home Whitening Kits
Prefilled Disposable trays

However, should I decide to undergo this procedure, I understand that in-office whitening treatments are considered generally safe by most dental professionals. I understand that although my dentist and dental assistant have been trained in the proper use of the ***Boost*** whitening system, the treatment is not without risk. I understand that some of the potential complications of this treatment include, but are not limited to:

Tooth Sensitivity/Pain – During the first 24 hours after ***Boost*** treatment, some patients can experience some tooth sensitivity or pain. This is normal and is usually mild, but it can be worse in susceptible individuals. Normally, tooth sensitivity or pain following a ***Boost*** treatment subsides within 24 hours, but in rare cases can persist for longer periods of time in susceptible individuals. People with existing sensitivity, recession, exposed dentin, exposed root surfaces, recently cracked teeth, abfractions (micro-cracks), open cavities, leaking fillings, or other dental conditions that cause sensitivity or allow penetration of the gel into the tooth may find that those conditions increase or prolong tooth sensitivity or pain after ***Boost*** treatment. It will be recommended that these patients wait to bleach until these issues are addressed.

Dry/Chapped Lips – The ***Boost*** treatment involves the mouth being kept open continuously for the entire treatment by a plastic retractor. This could result in dryness or chapping of the lips or cheek margins, which can be treated by application of lip balm, or petroleum jelly.

Bleach getting on soft tissue- sometimes the hydrogen peroxide can get on other areas besides the teeth, even though all protective protocol was followed. This may result in temporary "whiteness " in the gum, which will subside within 24 hours. Bleach may also touch soft tissue of the lip and can cause a painful sore/lesion, which may last a few days.
The basic procedures of ***Boost*** treatment and the advantages and disadvantages, risks and known possible complications of alternative treatments have been explained to me by this office and this office has answered all my questions to my satisfaction. As a general precaution, it is recommended that pregnant women consult with their doctor before undergoing this procedure.
In signing this informed consent I am stating I have read this informed consent (or it has been read to me) and I fully understand it and the possible risks, complications and benefits that can result from the ***Boost*** procedure.

_____ _____
Patient's Name (Printed) Patient's Signature & Date Signed