CONROE SMILES
CONFIDENTIAL PATIENT INFORMATION

Date: _____

PERSONAL INFORMATION

Patient Name: _____ SS#: _____

Preferred Name: _____

Drivers Lic. #: _____

Address: _____

Street City State Zip

Phone #: HOME: _____ CELL: _____

WORK: _____ EMAIL: _____

Birthday: _____ Sex: M or F

Marital Status _____ Spouse's Name _____ DOB: _____

Your Occupation: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone #: _____ 2nd #: _____

If you are completing this form for another person, what is your relationship to that person?

Name: _____ Relationship: _____

PERSONAL RESPONSIBLE FOR ACCOUNT

Write "Same As Above" if Info is Same

Name: _____ Relationship: _____

Address: _____

Street City State Zip

Telephone: Home: _____ Work: _____

SUBSCRIBER & DENTAL INSURANCE INFORMATION

Primary Insurance Co.: _____ Insurance Phone # _____

Name

_____

Street City State Zip

Employee: _____ SS#: _____ Relationship: _____

Employee DOB: _____ Employer Company Name: _____

Employer Phone #: _____ Policy #: _____

Employer Address, City, St, Zip: _____

I understand that I am responsible for co-pays, deductibles, or any balance not covered under my insurance policy. I also understand that I am responsible for any collection fees in addition to any outstanding account balance. $75 cancellation fee if 48 hour notice is not given.

Signature: X _____ Date: _____

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 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 smoke cigarettes or cigars? ☐ Yes ☐ No How much/How long

Do you use smokeless tobacco? ☐ Yes ☐ No How much/How long _____

Do you use controlled substances? ☐ Yes ☐ No Type of substance and How much/How long _____

Women: Are you

Pregnant ☐ Yes ☐ No Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Type_____ Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Iodine ☐ Sulfur Drugs ☐ Sedatives

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Respiratory Problems	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Diabetes I or II	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anorexia / Bulimia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthritis / Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Veneral Disease	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No				

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Has your doctor recommended pre-medication for dental treatment ☐ Yes ☐ No

DENTAL INFORMATION

PLEASE CIRCLE YES, NO, OR DON'T KNOW

YES NO DON'T KNOW Do you feel you may have bad breath at times?

YES NO DON'T KNOW Do your gums bleed when you brush?

YES NO DON'T KNOW Are your teeth sensitive to cold, hot, sweets or pressure?

YES NO DON'T KNOW Have you had any periodontal (gum) treatments?

YES NO DON'T KNOW Do you occasionally have an unpleasant taste in your mouth?

YES NO DON'T KNOW Have you ever had orthodontic (braces) treatment?

YES NO DON'T KNOW Do you have headaches, ear aches or neck pains?

YES NO DON'T KNOW Do you wear removable dental appliances?

YES NO DON'T KNOW Are you interested in Cosmetic Dentistry for your smile?

YES NO DON'T KNOW Have you ever had a serious/difficult problem with any previous dental treatment?

If yes, please explain: _____

Why are you here today? _____

Signature: X_____ **Reviewed by:**_____ **Date:** _____

CONROE SMILES
2101 MAUREL DR.
CONROE, TX 77304
RELEASE FORM

PATIENT NAME_____

DOB_____

By signing this paper below, I give my permission to the person(s) listed to receive information about my care along with financial arrangements. I understand my dental provider will use their professional judgment to ensure that information shared with my family/friend will require a signed HIPAA compliant authorization. This permission will be considered ongoing until revoked in writing.

NAME	RELATIONSHIP	PATIENT INITIALS

_____
Signature of Patient or Legal Guardian Date

_____
Witness Date

CHARLES J. PORTALES, DDS, PC
JAMES A. LUTONSKY, JR, DDS
2101 MAUREL DRIVE
CONROE, TX 77304
936-494-0200

INFORMED CONSENT FOR DENTAL TREATMENT

I consent to treatment by Dr. Charles J. Portales and their adjunctive staff for the conditions listed on my treatment plan. I also understand that treatment may be subject to change due to unforeseen complications.

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side affects
- Damage to adjacent teeth or fillings
- Post operative infection
- Post operative bleeding that may require additional treatment
- Sinus involvement during treatment of upper arch.
- Involvement of the nerves during treatment resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas.
- Bruising, swelling, sensitivity, or pain.
- Failure of the dental procedures necessitating additional treatment (i.e. root canal therapy).
- Breakage of dental instruments inside tooth, making additional treatment necessary.
- Complications during treatment necessitating referral to a specialist.

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of opting for non-treatment. Any fee(s) involved have been explained to my satisfaction. All of my questions have been answered. This authorization will remain in effect until cancelled in writing by patient or guardian.

Patient's Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Witness_____ Date_____

Charles J. Portales, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual Refused To Sign.
- o Communications Barriers Prohibited Obtaining The Acknowledgement
- o An Emergency Situation Prevented Us From Obtaining Acknowledgement
- o Other (Please Specify)

_____
Team Member Signature & Date

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This Form is education only, does not constitute legal advice, and covers only federal, not state, law. (August 14, 2002)

NOTICE OF PRIVACY PRACTICES
THE OFFICE OF CHARLES J. PORTALES, DDS

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 practice, 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 takes effect 04/14/2003, 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 DICLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment 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 is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We ay disclose your health information to a family member, friend or other person to the extent necessary to help you 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 use or 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 relevant 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 allowing 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 or safety or the heath 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 authorized 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 $1.00 for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that 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, for the last six years, but not before April 14, 2003. 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.

Restriction: 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 means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, provide satisfactory explanation how payments will be handled under the alternative mans 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 Website or by electronic e-mail, you are entitled to receive this Notice in written form.

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This Form is educational only, does not constitute legal advice, and covers only federal, not state law. (August 14, 2002)