Chet K. Gray DDS, Wesley D. Gray DDS
2701 Cuthbert Ave Midland , TX 79701
432-694-5741

Chart#: ____________
FOR OFFICE USE ONLY

Patient Information

Patient Name ________________________________ Date ________________
Last First MI

Gender: Male Female

Family Status: ________________

Social Security#:________________________ Birth Date ________________

Phone (Home): ________________________ Work ________________

Ext: ________________________ Best time to call: ________________

Email ____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F S

Address ________________________ Apartment # ________________

City ________________ State________________ Zip Code________________

Health Information

Date of Last Dental Visit: ________________ Reason for this visit ________________

Have you ever had any of the following? Please check those that apply:

AIDS	Excessive Bleeding	Liver Disease	Stroke
Allergies ________	Fainting	Mental Disorders	Tuberculosis
________	Glaucoma	Nervous Disorders	Tumors
Anemia	Growths	Pacemaker	Ulcers
Arthritis	Hay Fever	Pregnancy	Venereal Disease
Artificial Joints	Head Injuries	Due date:.	Codeine Allergy
Asthma	Heart Disease	Radiation Treatment	Penicillin Allergy
Blood Disease	Heart Murmur	Respiratory Problem	OTHER:
Cancer	Hepatitis	Rheumatic Fever	
Diabetes	High Blood Pressure	Rheumatism	________
Dizziness	Jaundice	Sinus Problems	
Epilepsy	Kidney Disease	Stomach Problems	________

Have you ever had any complications following dental treatment? Yes No

Ifyes, please explain: ____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

Ifyes, please explain: ____

Are you now under the care of a physician? Yes No

Ifyes, please explain: ____

Name of Physician ________________________ Phone: ________________

Do you have any health problems that need further clarification? Yes No

Ifyes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ ________________________

Signature of patient, parent or guardian Date

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other ____________

Name of person or office referring you to our practice: ________________________________

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: ______________________________

Gender Male Female Marital Status Married Single Child Other ________

Social Security # ________________ Birth date ________________

Phone (Home): ________________ (Work): ________________

Ext: ________________ Best time to call: ________________

Address: ________________ Apartment # ________________

Street

City ____________ State ____________ Zip Code ____________

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: ________________ Occupation ________________

Address: ________________ Apartment # ________________

City ____________ State ____________ Zip Code ____________

Phone ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all account exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me in writing, within the time *tor* payment thereof. I further agree that a waiver of any breach of any time or condition here under shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

____________________________________ ____________________

Signature of patient, parent or guardian Date

Relationship to patient ____________________________

____________________________________ ____________________

Signature of guarantor of payment/responsible party Date

Relationship to patient ____________________________

HIPPA
Acknowledgement of receipt

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information as mandated by the Federal Health Insurance Accountability and Portability Act and the Texas Medical Privacy Act. If you have any objections to this form, please ask to speak with our Compliance Officer in person or by main phone number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name ____

Signature ____

Date ____

CURRENT MEDICATION:

ALLERGIC TO:

CONSENT:

I give permission to the following name/names listed to have access to my records:

NAME DATE

Dental Treatment Consent Form

Please read and initial the items checked below,
read and sign the section at the bottom of the form.

Patient Name ________________________________

1. Work to Be Done

I understand that I am having the following work done:

Fillings	Extractions	Root canal
Bridges	Impacted teeth Removed	Nitrous Oxide
Crowns	General Anesthesia	Other ________________

Initials ___________________

2. Drugs and Medications

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Initials ____________________

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Initials ___________________

4. Removal of Teeth

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth ______________________________ and any others necessary for reasons n paragraph #3. I understand removing teeth does not always remove all of the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips tongue, and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials ___________________

5. Crown, Bridges and Caps

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, color) will be before cementation.

Initials ___________________

6. Dentures, Complete or Partial

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try in visit. I understand that most dentures requiring relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

Initials ____________________

7. Endodontic Treatment (Root Canal)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

Initials ____________________

8. Periodontal Loss (Tissue &Bone)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials ____________________

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Name of patient ____

____ ______________________

Signature of Patient Date

____ ______________________

Signature of Parent / Guardian (If patient is a minor) Date

HIPPA NOTICE OF PRIVACY PRACTICES
TEXAS MEDICAL PRIVACY ACT

Gray Cosmetic and Family Dentistry
2701 W. Cuthbert Ave
Midland, TX 79701

Gray Cosmetic and Family Dentistry is committed to protecting your privacy, both in the office and online. We make every effort to safeguard your personal data. We comply with all HIPAA requirements, including the gathering of personal information and online security.

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. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THIS PRACTICE WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes our Practice's policies, which extend to any health care professional authorized to enter information into your chart, all employees, *staff* and other personnel working for or with our Practice, and our business associates (labs, referring offices, physical therapists, dental supply companies, etc.).

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe ways we use and disclose protected health information. Each category provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place.

We use your medical information to provide current or prospective medical treatment or services to doctors, nurses, technicians, medical students, or hospital personnel *involved in your care.* We may discuss your medical information with you to recommend possible treatment options or alternatives. We may communicate to a referring office via a secured internet site to obtain your x-rays and patient information We may disclose your medical information to *others involved in your medical care* after you leave the Practice; this may include your family members, personal representatives *authorized by you* or by a *legal mandate.*

We may disclose your medical information for services and procedures so they may be billed and collected from you, an insurance company, or any third party payer. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician.

The final category under which we may use or disclose your protected health information without your permission is for health care operations. This includes a wide range of day-today activities performed by us such as quality assessment, case management, and care coordination, contacting other providers about care alternatives for you, conducting internal training programs for supervisory purposes, and activities associated with the licensing and issuance of credentials for our staff.

- **Appointment and Patient Recall Reminders**

  We may ask that you sign-in at the Receptionists' Desk, writing in a "Sign In" log on the day of your appointment. On the day of your appointment, we may call your name in the reception area to bring you to the treatment area. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve leaving an e-mail, a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.

- **To Avert a Serious Threat to Health or Safety**

  We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Public Health Risks**

  Law or public policy may require us to disclose medical information about you for public health activities..

- **Investigation and Government Activities**

  We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**

  If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may use such information to defend ourselves, or any member of our Practice in any actual or threatened action. We may release medical information if asked to do so by a law enforcement official.

CHANGES TO THIS NOTICE

We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. A copy of the current notice will be available in the Practice. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that Permission, in writing. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any discloses we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

You have the following rights regarding medical information we maintain about you:

You have the right to inspect and copy medical information that may be used to make decisions about your care..

If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information. To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. You have the right to request a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (7) years back.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). *We are not required to agree to your request, and we may not be able to comply with your request.* To request restrictions, you must make your request in writing and include what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like. You have the right to request confidential communications. You must make your request in writing.

Questions and Concerns

For more information or to file an internal complaint, please contact Gray Cosmetic and Family Dentistry.