A.C. Villarreal Family Dental
General Dentistry

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If Patient is a Minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Billing Address _____
Street City State Zip

Previous Address (if less than 3 yrs) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

Birthdate _____ Social Security # _____ Texas DL # _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Spouse's Maiden Name _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes, complete the following:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Relationship to patient (parent, grandparent, aunt, uncle, etc.) _____

Complete Address _____ Phone # _____

I understand that when appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

MEDICAL HISTORY

PATIENT NAME _____ Birth 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 _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

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 _____

A.C. Villarreal Family Dental

General Dentistry
1123 S. 10th
Edinburg, Texas 78539
956-318-3384

Financial Policy

We accept major credit cards, cash or checks at the time of service. If you qualify, we have available a third party (Care Credit) that will allow you to make payments for major services. Application needs to be made prior to your appointment, and usually, we receive approval within an hour or two.

We work with most dental insurers. Carriers vary, but we'll try to help you get the most benefit out of your particular policy. As a courtesy to you, we will submit your claim forms for you and answer any questions we can. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do require that you pay the portion that your insurance policy doesn't cover at each visit.

Any balance remaining after 60 days, becomes your responsibility, regardless of insurance coverage. At that time, you will be charged 1.50% per month on the remaining balance until it is paid.

_____ _____

Signature Date

A.C. Villarreal Family Dental

General Dentistry

1123 S. 10th
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956-318-3384

NOTICE TO PATIENTS, INSUREDS & GUARANTORS

Your Dental Plan will only pay the Doctor if the Dental services you receive are covered services under the terms and conditions of your Dental Plan. If you are a member of a preferred provider organization or other managed care plans, your Dental plan may reduce or deny your benefits if:

- **the services are deemed not Dentally necessary by their Dental staff**
- **the services were not performed in a PPO approved dental office**
- **the services were not approved, ordered or performed by a PPO approved Dentist.**
- **The service is not a covered Service**

Dental plans review dental services to determine if the services are Dentally necessary based on the information that is sent. In general Dentally necessary means services which are:

- **Appropriate and necessary for the symptoms, diagnosis or treatment of a dental condition**
- **Within recognized standards of dental practice**
- **Not primarily for the convenience of the dental plan member or the Dental Plan dentist**
- **The least costly of alternative methods which is determined by a dental review individual (who is many times not a licensed Dentist).**

Dr. Balli's/Villarreal's recommendations are made with the highest level of integrity based on his 28 years of experience and continued dedication to keeping current on Dental Education and the latest product reviews and usage.

For this reason Dr. Balli or Dr. Villarreal cannot accept the financial risk for services which you and he have agreed upon to be the best option for your individual case, but determined by your insurance company not to be.

Your financial agreement with Dr. Balli/Villarreal is to pay for all services you receive whether or not your Dental Plan determines the services to be a covered service or Dentally necessary.

_____ _____

Patient/Spouse/Parent/Guardian **if other than patient indicate relationship**

A.C. Villarreal Family Dental

General Dentistry
1123 S. 10th
Edinburg, Texas 78539
956-318-3384

Acknowledgement Of Receipt
Of
Notice Of Privacy Practices

I, _____ have received a copy of
(Name of Patient)

A.C. Villarreal Family Dental's **Notice of Privacy Practices.**

_____
(Signature Of Patient)

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign

_____ Emergency situation kept us from obtaining the patient's signature

_____ Language barriers kept us from obtaining the patient's signature

_____ Other _____

A.C. Villarreal Family Dental

General Dentistry

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. If you have any questions about this Notice please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this **Notice** and to maintain the privacy of your health information. We must also abide by the terms of this **Notice** while it is in effect. We reserve the right to change our privacy practices and the terms of this **Notice** at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

How We May Use and Disclose Your Protected Health Information

When we give you our **Notice of Privacy Practices** you will be asked to sign an **Acknowledgement Of Receipt**. Once you have received our **Notice** and signed the **Acknowledgement**, we will use your protected health information for treatment, payment and health care operations. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement Of Receipt as soon as reasonably practicable after the delivery of treatment. The following examples show the types of uses and disclosures of your protected health information that our offices is permitted to make.

Treatment: Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your dental care. We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: Your protected health information may be used and disclosed to pay your health care bills. Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training and conducting auditing or review activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. We may also call your name in the waiting room when your doctor is ready to see you. We may send you reminder postcards or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities for our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information.

Your Written Authorization Is Required For Other Uses Of Your Protected Health Information

Any other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided for in your authorization.

Use and Disclosure Permitted Without Authorization But With An Opportunity To Object

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your dental care or with payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions or other similar forms of health information.

Other Disclosures That may Be Made Without Your Authorization

Required By Law: We may use or disclose your protected 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 that of other persons.

Military Personnel and National Security: We may disclose the health information of Armed Forces personnel when requested by command military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities.

Worker's Compensation & Health Oversight Activities: We may disclose your protected health information to comply with Worker's Compensation Laws and to health oversight agencies when conducting investigations or inspections as authorized by law.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

You Have The Following Rights

Inspect and copy your protected health information. 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 practically do so. You must make the request in writing to obtain access to your health information. You may obtain access by sending a letter to our Privacy Officer listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your health information for a fee.

Request a restriction of your protected health information. 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.

Request alternative communications. 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, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Request an amendment to your health information. You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

Receive an accounting of disclosures we have made of your health information. You have the right to an accounting of disclosures of your health information that occurred after April 14, 2003. This accounting will be for purposes other than treatment, payment, or healthcare operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee.

Make a complaint about our privacy practices. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the bottom of this page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint or change the way we treat you.

To obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Effective Date: April 14, 2003

Privacy Officer: Arlene M. Villarreal Telephone: (956) 318-3384

Address: 1123 S. 10th St., Edinburg, TX 78539

A.C. VILLARREAL FAMILY DENTAL

PATIENT E-MAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, A.C. Villarreal Family Dental now has the eligibility to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

A.C. Villarreal Family Dental believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect you privacy, no confidential or personal information will be sent from A.C. Villarreal Family Dental does not share the names, e-mail addresses, and/ or telephone numbers of patients with any other company, or with any other patient.

Please print all information neatly and legibly.

Name_____

E-mail address_____

Cell Phone_____

- ☐ Yes, please sign me up to receive e-mail and text messaging confirmations
- ☐ I do **not** wish to be contacted via email. (Text messages only)
- ☐ I do **not** wish to be contacted via text messaging. (Email only)
- ☐ I do **not** wish to be contacted by either text messaging or email.

I hereby give A.C. Villarreal Family Dental Family Dental permission to send messages to me via email and/or text messaging as means of communication as indicated by my selection above.