

Canyon Creek Dentistry
1618 Canyon Creek Dr. Ste.110, Temple, TX 76502

Adult History and Health Questionnaire

Date: _____

Patient's Name: _____ SSN#: _____ Preferred Language: _____

DOB: _____ Age: _____ Gender: M or F Marital Status: _____ Race: _____

Address: _____ Apt# _____ City, State: _____ ZIP: _____

Home#: _____ Cell#: _____ Work#: _____

Email Address: _____

Employer: _____ Occupation: _____

Primary Dental Insurance Company: _____ Group#: _____

Insured Name: _____ Insured SSN#: _____

Secondary Dental Insurance Company: _____ Group#: _____

Insured Name: _____ Insured SSN#: _____

How did you hear about us? Insurance Co. Internet Phonebook Friend/Family Current Patient Doctor's Office

Whom may we thank for the referral: Name: _____ Number _____

CONSENT TO TREATMENT: By my signature, I authorize Canyon Creek Dentistry to perform procedures including, but not limited to, dental exam, prophylaxis (cleaning), taking radiographs or photographs, administering anesthetics and/or medications, restoring (filling) teeth, placing sealants, placing crowns, extracting (removing) teeth, endodontics (root canal) therapy, and other procedures he/she may deem necessary for my care. I give permission to have blood drawn for testing in the event of a needle stick or puncture wound to the provider during the course of the treatment. Radiographs, photographs and other records will remain the property of Canyon Creek Dentistry.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services are charged directly to the patient. We will file all necessary forms or reports to your insurance company. We do not render our services on the basis that insurance companies will pay our fees. By signing below, you authorize the release of any information relating to your dental work to your insurance company. Also, you authorize the payment of the dental benefits otherwise payable to you directly to Canyon Creek Dentistry. **Patients are responsible for any fees the insurance company does not cover.**

PAYMENT POLICY: Payments for the professional services must be made at the time service is rendered unless prior arrangements are made. I understand and agree that I am ultimately responsible for the balance on my account. If I fail to meet the arrangements that have been provided, I understand that my account will be turned over to a third party for collections as provided by the law. **A \$25.00 fee will be assessed on scheduled appointments not cancelled with a 48 hour notice.**

Date: _____

Patient: _____

Canyon Creek Dentistry

Kinnari Prajapati, D.D.S.

1618 Canyon Creek Drive, Ste. 110

254-771-5900

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand Canyon Creek Dentistry has the right to change its Notice of Privacy Practices from time to time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I have received the Health Insurance Portability and Accountability Act (HIPAA) information that was provided by Canyon Creek Dentistry.

Patient Name (please print): _____

Patient/Guardian Signature: _____ Date: _____

Staff Will Fill Out This Section If Patient's Signature Is 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 reasons:

____ Patient refuses to sign.

____ Emergency situation kept us from obtaining the patient's signature.

____ Language barriers kept us from obtaining the patient's signature.

____ Other _____