Legacy DENTAL GROUP
Family and Cosmetic Dental Center

"Where Family is First"

Patient Information

Date _____ SS# _____

Driver's License # _____

Patient _____

Address _____

_____
City State Zip

Sex: ☐M ☐F Age _____ Birthdate _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Occupation _____

Employer _____

Employer Address _____

Employer Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber's Name _____

Birthdate _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Spouse's Work (_____) _____

Cell Phone (_____) _____ E-Mail _____ Spouse's Cell Ph. (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate If you have had any of the following:

Bad Breath	☐Yes	☐No
Bleeding gums	☐Yes	☐No
Blisters on lips or mouth	☐Yes	☐No
Burning sensation on tongue	☐Yes	☐No
Chew on one side of mouth	☐Yes	☐No
Cigarette, pipe, or cigar smoking	☐Yes	☐No
Clicking or popping jaw	☐Yes	☐No
Dry mouth	☐Yes	☐No
Fingernail biting	☐Yes	☐No
Food collection between the teeth	☐Yes	☐No
Foreign objects	☐Yes	☐No
Grinding teeth	☐Yes	☐No
Gums swollen or tender	☐Yes	☐No
Jaw pain or tiredness	☐Yes	☐No
Lip or cheek biting	☐Yes	☐No
Loose teeth or broken fillings	☐Yes	☐No
Mouth Breathing	☐Yes	☐No
Mouth pain, brushing	☐Yes	☐No
Orthodontic treatment	☐Yes	☐No
Pain around ear	☐Yes	☐No
Peridontal treatment	☐Yes	☐No
Sensitivity to cold	☐Yes	☐No
Sensitivity to heat	☐Yes	☐No
Sensitivity to sweets	☐Yes	☐No
Sensitivity when biting	☐Yes	☐No
Sores or growths in your mouth	☐Yes	☐No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ○ Yes ○ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	○Yes ○No	Emphysema	○Yes ○No	Radiation Treatment	○Yes ○No
Anemia	○Yes ○No	Epilepsy	○Yes ○No	Respiratory Disease	○Yes ○No
Athritis, Rheumatism	○Yes ○No	Fainting or Dizziness	○Yes ○No	Rheumatic Fever	○Yes ○No
Artificial Heart Valves	○Yes ○No	Glaucoma	○Yes ○No	Scarlet Fever	○Yes ○No
Artificial Joints	○Yes ○No	Headaches	○Yes ○No	Shortness of Breath	○Yes ○No
Asthma	○Yes ○No	Heart Murmur	○Yes ○No	Sinus Trouble	○Yes ○No
Back Problems	○Yes ○No	Heart Problems	○Yes ○No	Skin Rash	○Yes ○No
Bleeding abnormally, with extractions or surgery	○Yes ○No	Hepatitis Type --Select One--	○Yes ○No	Special Diet	○Yes ○No
		Herpes	○Yes ○No	Stroke	○Yes ○No
Blood Disease	○Yes ○No	High Blood Pressure	○Yes ○No	Swollen Feet or Ankles	○Yes ○No
Cancer	○Yes ○No	Jaundice	○Yes ○No	Swollen Neck Glands	○Yes ○No
Chemical Dependency	○Yes ○No	Jaw Pain	○Yes ○No	Thyroid Problems	○Yes ○No
Chemotherapy	○Yes ○No	Kidney Disease	○Yes ○No	Tonsillitis	○Yes ○No
Circulatory Problems	○Yes ○No	Liver Disease	○Yes ○No	Tuberculosis	○Yes ○No
Congenital Heart Lesions	○Yes ○No	Low Blood Pressure	○Yes ○No	Tumor or growth on head or neck	○Yes ○No
Cortisone Treatments	○Yes ○No	Mitral Valve Prolapse	○Yes ○No		
Cough, persistent or bloody	○Yes ○No	Nervous Problems	○Yes ○No	Ulcer	○Yes ○No
		Pacemaker	○Yes ○No	Venereal Disease	○Yes ○No
Diabetes	○Yes ○No	Psychiatric Care	○Yes ○No	Weight Loss, unexplained	○Yes ○No

Do you wear contact lenses? ○ Yes ○ No

Women:

Are you pregnant? ○Yes ○No Due date _____ Are you nursing? ○ Yes ○ No

Taking birth control pills? ○Yes ○No

Medications

List any medications you are taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone (_____)_____

Allergies

☐ Aspirin	☐ Local Anesthetic
☐ Barbituates (Sleeping Pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex _____	_____

Updates (To be filled in at future appointments)

Has there been any change in you health since your last appointment? ○ Yes ○ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Has there been any change in your health since your last dental appointment? ○ Yes ○ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date_____

Doctor's Signature _____ Date_____

Ben A. Bratcher, D.D.S.
J. Michael Hackney, D.D.S.
Glenn A. Stern, D.D.S.
Gerard Macy, D.D.S.

Legacy DENTAL GROUP
Family and Cosmetic Dental Center

Financial Policy

It is our goal to provide the best possible dental care for you, and at the same time avoid any confusion regarding your treatment, fees, insurance and payments. For this reason we have created a financial policy statement based on some frequently asked questions.

Q. ***When is payment due?***
A. Payment is expected when services are rendered. We will try to provide you in advance of treatment with the amount of payment that will be required at each visit so that you have the opportunity to discuss treatment alternatives or payment arrangements if finances are a concern.

Q. ***What about insurance? I have coverage. Will your office accept my insurance benefits and then bill me after insurance has paid its portion?***
A. We gladly file and accept your insurance. Please understand that at the time of your appointment you will be asked to pay your deductible as well as any portion of the treatment fees that we estimate will not be covered by your insurance.

If you assign your benefits to be paid directly to our office, we ask that you sign an authorization for direct payment. Our office allows a maximum of ***90* days** for collection of payment from an insurance company. If after that period of time insurance has still not been paid, direct payment from the patient is required.

Q. ***Are fees available for examination?***
A. Absolutely! After an examination, we can determine the type of treatment you need and will be delighted to discuss our fees with you. Please contact our financial coordinator if you have any questions in this regard.

Q. ***Do you allow payment plans?***
A. We do realize that, on occasion, financial circumstances are unavoidable. However, we have a limited time that we extend our payment plans and all outstanding balances are subject to 1.5%/month finance charges in addition to collection fees. If you have a financial concern, we ask that you speak with our financial coordinator.

Q. ***Do you accept credit cards payments?***
A. We are pleased to accept most major credit cards.

There is a $25.00 service fee on all returned checks.

Should your account be turned over to a collection agency due to non-payment, you will be responsible for any and all collection fees.

I have read and agree to the above terms.

_____ ____/____/____

Responsible party's signature Date

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Gerard Macy, D.D.S.
240 E Hwy 243 Canton, TX 75103
Phone: (903) 567-4881 Fax: (903)567-5149

NOTICE OF PRIVACY PRACTICES

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 practices, 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 **4/14/03,** 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 DISCLOSURES 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 was 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 may disclose your health information to a family member, friend or other person to the extent necessary to help 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 information to the extent necessary to avert a serious threat to your health or safety or the health 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 $0.___ for each page, $___ 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 6 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, and provide satisfactory explanation how payments will be handled under the alternative means 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Health Professions Council** **Telephone: 1-800-821-3205**

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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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Canton, Tx 75103
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Announcing
Smile Reminder

We are committed to providing the highest level of service and as such we have recently implemented a new technology solution that will allow us to send you important, timely messages without interrupting your busy schedule.

This exciting new service gives us the ability to send text messages to the device of your choice (your cell phone or email). Since we send text you don't have to answer a call. Simply read it and respond at your convenience. We think this is the best solution for reminding you of your appointments and keeping in touch.

We will continue sending you reminder cards and touch base with you by phone.

Sending reminders to your mobile devices allows us to remind you even when you're not at home. We know that no one wants to miss appointments, but sometimes activities of the day get overwhelming for all of us and we forget. With this in mind we are excited to be able to remind you the same day of your appointment. Think of this as a "tap on the shoulder" simply telling you that we are excited to see you for your appointment.

In addition, we will be sending out messages with special opportunities for discounts or new services!!

If you would like to take advantage of this wonderful service, please fill out the following fields to receive text messages and emails from our office:

If you prefer not to receive these messages, please check here ☐

Name: _____ Email: _____

Cell Phone: _____

Thanks for being such a great patient!

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*We will file dental insurance claims as a courtesy to our patients.

*Please note that these prices are **ONLY ESTIMATES** based off the current information we have received from you and your insurance company and you agree that you are responsible for the fees associated with your treatment. We cannot guarantee what your insurance company will pay on your claim.

*It is patients responsibility to know your insurance policy and any frequency and limitations your policy may have. Please contact your insurance company or your plan policy booklet for an explanation of benefits.

*Please note that these **ESTIMATED** prices are only good for 9 months from the day we diagnose the treatment. If your insurance coverage changes it may affect the treatment plan estimates. Please inform us of any changes to your insurance and request a new treatment plan estimate.

*Total patient portion is due at time of service unless pre-approved financial arrangements have been made with our financial coordinator.

Signature_____

Date_____