

Chart #: \_\_\_\_\_  
FOR OFFICE USE ONLY

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name) Gender: \_\_\_\_\_ Family Status: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street 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:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Ulcers             |
| _____                                      | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Venereal Disease   |
| _____                                      | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Hay Fever           | Due date: _____                               | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Joint Replacement  |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Smoking            |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Recreational Drugs |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> OTHER: _____       |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems       |   |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Stomach Problems     |   |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke               |   |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Tuberculosis         |   |

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
- Have you had any surgeries? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
- Are you currently taking any medications? ? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician? ☐ Yes ☐ No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification? ☐ Yes ☐ No  
If yes, 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: \_\_\_\_\_  
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code

### Employment Information

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

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Last First MI Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

I have completed this form to the best of my knowledge and I will inform the office of any changes

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of guarantor of payment/responsible party \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## FINANCIAL OFFICE POLICY

In consideration for the professional services rendered to me, I agree to pay for these services, at the time the services are rendered unless financial arrangements are made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service. Our fees reflect our commitment to the quality of care that our patients deserve. If you have insurance, we are happy to assist you in processing your insurance claims to maximize your benefits. INSURANCE ESTIMATES will assist you in determining your APPROXIMATE OUT OF POCKET EXPENSE. Please note THAT INSURANCE ESTIMATE ARE NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY. We ask you to keep in mind that your insurance policy is a contract between your employer, yourself and the insurance company. We are not part of that agreement.

REGARDLESS OF INSURANCE COVERAGE, ALL FEES AND ACCOUNT BALANCES ARE THE PATIENTS RESPONSIBILITY.

As a patient of Safari Dental I understand my financial responsibility and also give consent to use this signature on all insurance claims, to release records, including X-rays for insurance purposes only. I also give you permission to contact me by phone or e-mail concerning any matters related to my treatment or account. I give consent for my dental treatment as deemed necessary.

Thank you for choosing Safari Dental.

## HIPAA

### ACKNOWLEDGEMENT OF RECEIPT / REVIEW OF NOTICE OF PRIVACY PRACTICES

I have received/reviewed a copy of this offices Notice of Privacy Practices.

**\*\* IT IS YOUR LEGAL OPTION TO NOT SIGN THIS ACKNOWLEDGEMENT; HOWEVER, OUR POLICY STATES THAT IF WE DO NOT HAVE THIS SIGNED ACKNOWLEDGEMENT FROM YOU, WILL NOT BE ABLE TO PROVIDE YOU WITH OUR SERVICES.\*\***

_____	Date: _____	Relationship to Patient: _____
Signature of patient, parent or guardian		
_____	Date: _____	Relationship to Patient: _____
Signature of guarantor of payment/responsible party		

- IF YOU WOULD LIKE A COPY OF THIS PAGE, PLEASE NOTIFY THE FRONT DESK.

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### 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

- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other

If other, was marked, please specify:

Name of office personnel: \_\_\_\_\_

### **Appointment Policy**

We value your time, so you can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. When you make an appointment with us, please be on time since we have reserved our time just for you.

Please make every effort to attend your scheduled appointment. If you must change an appointment, please provide us at least two (2) working day advanced notification, so we may use our time to accommodate other patients. Broken and missed appointments create scheduling problems for other patients and our practice.

After three (3) missed appointments without proper notification of cancellation (24 hours prior), the office does reserve the right to refuse the continuation of treatment, and the insurance company will be notified. Please be aware that certain insurance companies will deny coverage if dental benefits are not used and/or scheduled visits or missed.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Transfer of Authority for Non Parent/Legal Guardian

Dental Treatment @ Safari Dental



I, \_\_\_\_\_, am the Parent/Legal Guardian of \_\_\_\_\_. I authorizing \_\_\_\_\_ to make any decisions on my behalf, in reference to my child, for dental treatment that may be required. I understand that any restorative treatment will not be completed, until I sign the original treatment plan. At that time, If I am unable to bring my child for any reason, the above listed person/persons have my permission to make any judgment decisions pertaining to the treatment of my child. I understand that if my child requires any type of sedation, It is my responsibility to bring my child to any and all visits. I also understand I am responsible for any communication of medical changes in my Childs history, and any medical releases that are required by Safari Dental.

I understand Safari Dental's policy on Transferring Authority to another care giver. I understand that the person/persons listed above, are required to bring photo ID to be kept in my Childs file at all times.

I can be reached @ \_\_\_\_\_, if Safari Dental has any questions regarding the treatment of my child.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## How did you hear about our office?



- ☐ **Safari Patient** \_\_\_\_\_
- ☐ **Doctor** \_\_\_\_\_
- ☐ **Location** \_\_\_\_\_
- ☐ **Billboard/Ad** \_\_\_\_\_
- ☐ **Insurance** \_\_\_\_\_
- ☐ **Other** \_\_\_\_\_



# NOTICE OF PRIVACY PRACTICES

**Safari Dental & Orthodontics**  
**1601 N Texas Ave. #150**  
**Bryan, TX 77803**  
**(979) 985-3093**

**Privacy Officer: Teresa Booker**

**Effective Date: March 17, 2017**

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical/ dental information. We make a record of the dental care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality dental care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this dental practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical/ dental information. It also describes your rights and our legal obligations with respect to your medical/ dental information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

## **A. How This Dental Practice May Use or Disclose Your Health Information**

This dental practice collects health information about you and stores it in a chart [and/or on a computer][and in an electronic health record/personal health record]. This is your dental record. The dental record is the property of this dental practice, but the information in the dental record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical/ dental information about you to provide your dental care. We disclose medical/ dental information to our employees and others who are involved in providing the care you need. For

example, we may share your medical/ dental information with other dentists or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical/ dental information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical/ dental information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical/ dental information about you to operate this dental practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your dental plan to authorize services or referrals. We may also use and disclose this information as necessary for dental reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical/ dental information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or dental plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical/ dental information to contact and remind you

about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical/dental information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical/ dental information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying



or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we may be required make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this dental practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another dentist or dental group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

## **B. When This Dental Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this dental practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this dental practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical/ dental information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your

child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this dental practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this dental practice, except that this dental practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this dental practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of

these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

#### **D. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

#### **E. Complaints**

Complaints about this Notice of Privacy Practices or how this dental practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

#### **Region VI - Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)**

Jorge Lozano, Regional Manager  
Office for Civil Rights  
U.S. Department of Health and Human Services  
1301 Young Street, Suite 1169  
Dallas, TX 75202

Voice Phone (800) 368-1019  
FAX (214) 767-0432  
TDD (800) 537-7697  
[OCRMail@hhs.gov](mailto:OCRMail@hhs.gov)

The complaint form may be found at  
[www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf](http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf)

You will not be penalized in any way for filing a complaint.