Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Home Phone (_____) _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Child ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

In case of emergency who should be notified? _____ Phone (_____) _____

Preferred Confirmation Number _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ Insurance Phone (_____) _____

Group # _____ Member ID # _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone (_____) _____

City _____ State _____ Zip _____

Employer _____ Business Phone (_____) _____

Insurance Company _____ Soc. Sec. # _____

Group # _____

Please Complete Other Side

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 of 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
Arthritis, 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	Open Heart Surgery/Heart Surgery	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Hepatitis Type _____	☐ 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 Type _____	☐ 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 currently taking and the correlation diagnosis:

Medicine:	Diagnosis:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Pharmacy Name_____

Phone_____

Reason for Today's Visit?

_____

_____

_____

How did you hear about us?

☐ Friend _____

☐ Mail

☐ Neighborhood Newsletter

☐ Magazine

☐ Other _____

Health History

Patient Name: _____Date:_____

Have you taken or are you currently on any oral or IV Bisphosphonates?

Some examples of these drugs are: (Please circle any that apply)

Didronel (Etidronate)

Skelid (Tiludronate)

Fosamax (Alendronate)

Actonel (Risedronate)

Boniva (Ibandronate)

Aredia (Pamidronate)

Zometa (Zoledronate)

Reclast (Zoledronate)

Handley Dental Policies

There is a $30 Fee for Returned Checks.

If you have to cancel or reschedule an appointment with Handley Dental, please give us 24 hours notice so that we can offer the time to someone waiting for treatment. Habitual broken appointments will result in a charge for the time reserved.

Cell phone use is prohibited in the treatment areas as a courtesy to Dr. Handley, Staff and all patients.

Children need to remain seated with the parents in the waiting room while other members of the family are having treatment due to the privacy policy's of this office.

Patient Signature: _____ *Date:* _____
(Under 18 parent or guardian signatures only)

Copy of this letter is available at your request

Thank You,
Handley Dental Staff

Handley Dental
10730 Barker Cypress
Cypress, Texas 77433

Dear Patient:

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception – dental insurance was not designed to pay for *all* dental care. Most contracts with insurance companies have limits and/or various degrees of co-payment. These contracts are decided upon by your employer, or whoever chooses the plan.

All levels of payment by insurance companies are governed by the premiums paid. They have nothing to do with the actual costs charged by our office. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. ***The treatment recommended by our office is never based on what your insurance company will pay; it is based on your needs.*** Your treatment should not be governed by your insurance contract.

However, it should be understood that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, you may feel free to ask any member of our staff for clarification on services, billing, and insurance.

I have read and understand the above information.

Patient Signature: _____ Date: _____

Ron Handley, D.D.S.
10730 Barker Cypress Ste A
Cypress, Tx.77433
(281) 304-4744

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices ("Notice"). A paper copy of the completed Notice is available upon request. In addition, a copy of the Notice is posted at our front desk in the following location:

Front Desk

IT IS OUR PLEASURE TO INFORM YOU HOW DENTAL/MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We understand that your dental/medical information is personal to you, and we are committed to protecting the information about you.
As our patient, we create dental/medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law we are requested to make sure that your protected health information is kept private.

How will we use and/or disclose your information? Here are a few examples (for more details please request a copy of our Notice from our receptionist).

- **For dental/medical treatment**
- **To obtain payment for our services**
- **In emergency situations**
- **For appointment and patient recall reminders**
- **To run our practice more efficiently and ensure all our patients receive quality care**
- **To avert a serious threat to health or safety**
- **For worker's compensation programs**
- **In response to certain request arising out of lawsuits or other disputes**

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Administrator. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

You have certain rights regarding the information we maintain about you. These rights include:

- **The right to inspect and copy**
- **The right to amend**
- **The right to an accounting of disclosures**
- **The right to request restrictions**
- **The right to a paper copy of this notice**
- **The right to request confidential communications**

Handley Dental

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this 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)

_____

_____

_____