PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Paul W. Newman

Consent for Dental Treatment

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment that I may authorize. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I also understand that in some cases associated lab fees may be my financial responsibility.

Treatments that may be included in my Treatment plan, but are not limited to:

▪ Crown ▪ Bridge ▪ Root Canal

▪ Dentures ▪ Extractions ▪ Composite fillings

I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching, pain, nausea and vomiting or more severe allergic reactions. I have informed Dr. Newman of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

I understand I will have the opportunity to have all my questions answered by Dr. Newman and I certify that I understand English. My signature below signifies that I understand the information I have been provided with above and the risks and complications that could be associated with dental treatment. I hereby give consent for any dental treatment I may receive.

Patient's (or Legal Guardian's) Signature *Date*

Paul W. Newman D.D.S.
MEDICAL AND DENTAL HISTORY

Personal Physicians Name: _____
Address and Phone #:_____
The date of you last dental visit: _____
Are you in good physical health: □ Yes □ No
Have you ever been hospitalized for an operation or illness? _____
Are you currently under the care of a physician? □ Yes □ No
If yes please explain: _____
Do you smoke or use tobacco products? □ Yes □ No
Are you taking any medication prescribed by a dentist or physician? □ Yes □ No
If yes please list: _____
_____

Do you need to be pre medicated before dental treatment? □ Yes □ No
Have you ever had any of the following diseases or medical problems?
□ Artificial Joint
□ Heart Attack/Stroke/Pacemaker/Heart Surgery □ Cancer/Chemotherapy
□ Heart Murmur/Rheumatic Fever □ HIV/Aids
□ Hepatitis/Liver disease □ Shingles
□ Anemia □ Kidney Problems
□ High/Low Blood Pressure □ Sinus Problems
□ Severe Headaches □ Fever Blisters
□ Epilepsy/Seizures/Fainting Spells □ Psychiatric Problems
□ Drug/Alcohol Abuse □ Tuberculosis
□ Hemophilia/Abnormal Bleeding □ Sickle cell Disease
Please list any other serious medical conditions that are not listed above:
_____
_____

Are you allergic to any of the following?
□ Penicillin □ Sulfas or any other Antibiotic
□ Dental Anesthetics □ Codeine/Vicodin or Similar pain killers
Please list all allergies: _____

Why have you come to the dentist today? _____
Do you like your smile? _____

Are you under any unusual stress at home or Work? □ Yes □ No
Do you experience stress or anxiety when visiting the dentist? □ Yes □ No
Do you have any pain or discomfort in your jaw joints? □ Yes □ No
Do you grind your teeth? □ Yes □ No
How would you rate your dental health? □ Good □Fair □Poor
Do your gums ever bleed? □ Yes □ No

Women: Are you or do you think you may be pregnant? □ Yes □ No Are you nursing? □ Yes □ No

I understand the information I have been given today is correct to the best of my knowledge. I also understand that the information I provide will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical condition.

Signature _____ Date _____

Paul W. Newman D.D.S.

REGISTRATION

Patient's Name: _____Birthday: _____Sex_____

If Child: Parents Name_____

Social Security# _____Driver's License #_____

Address_____

City/St/Zip_____

Phone: Hm: _____Wk _____ Cell _____

Email: _____

Employer _____

Marital status: M_____ D_____ S_____

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

Do you have Dental Insurance? Yes_____ No_____

Dental Insurance:

Employee Name: _____DOB:_____

Employee Social Security #: _____Group:_____

Employer_____

Name of Insurance Co:_____

Policy ID:_____ Ins Phone #: _____

My consent to disclosure of records shall be effective until I revoke it in writing.
I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid by my dental carrier.

Signature:_____ Date: _____

Dr. Paul W Newman

1011 Augusta Dr. #106

Houston, Texas 77057

To Our Valued Patients:

We understand that from time to time events may occur which prevent you from keeping appointments. We are asking that you provide us with 24 hour notice should you need to cancel or change your appointments in order to avoid $45.00 cancellation/no show fee.

Thank you.

Dr. Newman and Staff

Patient Name: _____

Signature: _____ Date: _____