Anna Willison, D.D.S., F.A.G.D.
Eugene Dahl, D.D.S., M.S.

7777 Forest Lane, Suite A-309
Dallas, TX 75230

REGISTRATION

Patient's Last Name _____ First _____ Middle _____

I prefer to be called _____ Sex F/M Date of Birth _____ Age _____

Social Security # _____/____/_____ Driver's License # _____ State _____

Home Address _____

City _____ State _____ Zip _____

Mailing address (if different) _____

Home phone _____Work phone _____Cell _____

Email address _____

Preferred form of communication ☐ email ☐ text ☐ phone ☐ cell ☐ home ☐ work

Employer _____ Occupation _____

Spouse's Name _____ Spouse's Occupation_____

Emergency contact _____ Best number to reach _____

Is an immediate family member a patient at this office? _____

How did you hear about us? _____

Person Responsible for Account

☐ Self ☐ Other, Name: _____ Relationship _____

Sex F/M Date of Birth ____/_____/____ SS # _____/____/_____ DL # _____ State ____

Address_____ City_____ State ___ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____

Employer _____ Occupation _____

Employer's address _____

Dental Insurance Carrier _____Customer Service # _____

Claims mailing address _____

Medical Insurance Carrier _____Customer Service# _____
Med. Ins. Member ID _____

Patient or Legal Guardian Name Signature Date

MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

1. Are you in good health? Yes No
2. Has there been any change in your general health within the past year? Yes No
3. Are you now under the care of a physician? Yes No
   Physician's name _____phone # _____
3. Have you ever been hospitalized or had a serious illness? Yes No
   If yes, explain: _____
4. When was the last time you saw a physician? _____ Reason_____
5. List allergies and unusual reactions to medications or substances: _____

_____

6. Have you ever had an unusual skin reaction to jewelry or other metals? Yes No
7. Are you allergic to Latex? Yes No
8. List of current medications, vitamins, herbs:

_____

_____

9. Weight _____ Height _____
10. Do you have or have you ever had any of the following?

Heart disease	yes	no	Obesity	yes	no
Heart murmur or valve problem	yes	no	Kidney problems	yes	no
Pacemaker or Defibrillator	yes	no	Digestive problems	yes	no
Rheumatic Fever	yes	no	Autoimmune disorders	yes	no
Stroke	yes	no	Arthritis/Rheumatism	yes	no
High Blood Pressure	yes	no	Thyroid problems High/Low	yes	no
Circulatory Problems	yes	no	Tumors or Cancers	yes	no
Epilepsy/Seizures	yes	no	Chemotherapy treatments	yes	no
Fainting spells	yes	no	Radiation treatments	yes	no
Anemia	yes	no	Joint replacement	yes	no
Excessive bleeding	yes	no	HIV or AIDS	yes	no
Diabetes or High Blood Sugar	yes	no	Sexual transmitted disease	yes	no
Liver problems	yes	no	Head injuries	yes	no
Hepatitis or Jaundice	yes	no	Physical trauma	yes	no
Blood transfusion	yes	no	ADD/ADHD	yes	no
Eye problems	yes	no	Autism	yes	no
Sinus trouble	yes	no	Anxiety or nervousness	yes	no
Hay Fever or seasonal allergies	yes	no	Depression	yes	no
Lung problems	yes	no	Memory problems	yes	no
Tuberculosis	yes	no	Psychological disorders	yes	no
Asthma	yes	no	Drug addiction	yes	no
Emphysema	yes	no	Alcohol addiction	yes	no
Sleep Apnea	yes	no	Other	yes	no

Please explain any "yes" _____

_____

Any other health problems that need further clarification? _____

_____

12. Are you using recreational drugs? What type? _____ Yes No
13. Do you or did you ever smoke cigarettes or use smokeless tobacco Yes No
How long? _____How much per day? _____ When quit? _____
13. Do you drink alcoholic beverages? Yes No
How much per day? _____ How much per week? _____
14. Are you employed in a job which exposes you regularly to x-rays or other radiation? Yes No
15. Do you have any other disease, condition, or medical problem not listed above that you think the Doctor should know about? Yes No

If yes, explain _____

Women

16. Are you pregnant, or is there a possibility you might be pregnant? Yes No
17. Are you presently nursing? Yes No

DENTAL HISTORY

1. Previous dentist _____ City _____ State _____
2. Was your pattern of visits ☐ regular ☐ infrequent ☐ sporadic ☐ never
3. Date of last dental visit _____ What was done at that visit? _____
4. Date of last teeth cleaning _____
5. Are you having specific dental problems? Yes No
6. Have you ever been pre-medicated with antibiotics before dental treatment? Yes No
7. Does dental treatment make you nervous? Yes No
8. Have you ever had any serious trouble associated with dental treatment, or had bad experience in a dental office? Yes No
Please explain _____
9. Do you have or experience any of the following?

Sensitive teeth	yes	no	Canker sores	yes	no
Teeth grinding or clenching	yes	no	Jaw joint pain	yes	no
Bad breath	yes	no	Jaw joint clicking/popping	yes	no
Loose teeth	yes	no	Food packing between teeth	yes	no
Bleeding gums	yes	no	Dry mouth	yes	no
Cold sores or fever blisters	yes	no	Tingling in tongue, lips, or jaw	yes	no

Have you had ☐ injury to teeth/jaw ☐ oral surgery ☐ orthodontics ☐ gum treatments

10. How often do you brush your teeth? _____ floss your teeth? _____
11. What type of toothbrush do you use? _____ other products? _____
12. Is there anything you would like to change about the appearance or function of your teeth?
Explain: _____
13. What are you most concerned about? _____
14. Please tell us anything else you would like the Doctor to know about yourself, your dental condition, your fears, etc. _____
_____

I certify that my answers are true and accurate.

_____ _____ _____ _____
Patient's Signature Date If Dependent - Legal Guardian's Name and Signature

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AUTHORIZATIONS

Please initial:

_____ I understand that the comprehensive examination will include examination of teeth and gums, oral cancer screening, and periodontal evaluation. I understand that radiographs (x-rays) are a vital part of an examination.

_____ I hereby authorize Dr. Anna Willison, Dr. Eugene Dahl, and their Staff to take necessary radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

_____ I understand that if I present with an urgent need, such as pain or infection, a limited examination will be done to address the problem. I understand that a comprehensive examination will be completed at a future appointment.

_____ I authorize the release of any information concerning my (or my minor's) health care, medical history, advice, and treatment to another dentist, if applicable (example: referral to a specialist).

_____ I hereby authorize the release of any information relating to insurance benefits claims and authorize payment of my dental benefits directly to Anna Willison, D.D.S. or Eugene Dahl, D.D.S.

_____ I understand that my insurance benefits plan may pay less than the actual bill for services and that I am fully responsible for payment of my account.

_____ If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody. The adult is also required to physically remain in the office for the duration of treatment.

_____ By providing my email and phone numbers I am giving the office of Dr. Anna Willison and Dr. Eugene Dahl permission to contact me via email, text or by phone for the purposes of meeting my dental needs and any other necessary communication.

_____ To the best of my knowledge, all of the answers on the medical history and other information provided are true and correct. If I ever have changes in my health, I will inform the doctors as soon as possible.

_____	_____	_____
Patient or Legal Guardian's Name	Signature	Date

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FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions, please discuss them with us.

Your Insurance

As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. It is illegal for healthcare providers to write off any patient's out of pocket expenses. All estimates quoted are based upon information provided to us by your insurance company and are **estimates only**, not a guarantee of payment. Because insurance policies vary wildly, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. The patient is ultimately responsible for all charges incurred.
Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will be resubmitted by our office and ask that you pay in full and have your insurance company reimburse you. We will be happy to provide any information or documentation you may require. Our estimates are subject to final approval by your insurance company; therefore, the amount due to our office is subject to change.

Missed Appointments

Our first and only priority is our patients and the quality of care. It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities. We do require 24 hrs notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. A fee of $75 may be charged for failed or cancelled appointments with less than 24 hrs notice.

Returned Check Fee is $30.00

Service Charge

A service charge of 1.75% per month (21% per annum) will be charged on unpaid balance on accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

Collections

If your account is turned over to our collection agency, you will be responsible for the collection fee charge to us by the agency in addition to your outstanding balance.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____ _____

Patient or Legal Guardian's Name Signature Date

Anna Willison, D.D.S., F.A.G.D.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You may refuse to sign this acknowledgment, however, in refusing we will not be allowed to process your insurance claims for payment.

I, _____, have had full opportunity to read and consider the contents of the Notice of Privacy Policies of this office. I understand that, by signing this form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Please list any other parties who can have access to your dental health information (spouse, parents, step parents, grandparents, or any other caretakers who are allowed to have access to this patient's records).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

We may utilize all forms of communication you provided us on the Registration form to schedule and confirm appointments, to contact you regarding treatment and billing information, lab test results, as well as occasional marketing. If you wish to add any restrictions on communication from this office, please specify below:

_____

Please be aware that our phone system is part of an extensive Medical City Dallas Hospital phone system. Unless you have our number programmed into your telephone, our identity on the Caller ID will simply show "UNAVAILABE".

_____ _____ _____
Signature of Patient or Legal Representative Relationship Date

Office Use

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 acknowledgment

Signature of Privacy Officer: _____

Notice of Privacy Practices

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

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Dallas Center for Oral Health & Wellness, the office of Drs. Anna Willison, D.D.S. and Eugene Dahl, D.D.S. ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

III. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use your health information. These examples are not meant to be exhaustive.

1. Treatment - to provide you with dental treatment or services, such as cleaning, examining your mouth, or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment - to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations – in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders – to contact you to remind you of a dental appointment by using a postcard, letter, call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services - to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends - We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object, or if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates - We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf, or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

8. Disclosures Required by Law - We are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA. Or, to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime. Also, in lawsuits in response to a court or administrative order, a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

9. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

10. Victims of Abuse, Neglect or Domestic Violence - reporting to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

11. Health Oversight Activities - reporting to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

13. Coroners, Medical Examiners and Funeral Directors - to allow them to carry out their duties.

14. Research Purposes - We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

15. Serious Threat to Health or Safety - If we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

16. Specialized Government Functions - We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

17. Workers' Compensation - to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

IV. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

V. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the last page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B.Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

C. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the last page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

D. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice.

E. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

VI. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information.

VII. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will post the revised Notice on our website and in our office, and will provide a copy of it to you on request. The effective date of this Notice is 01/2015.

III. How to Make Privacy Complaint. If you have any questions or complaints about your privacy rights, or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you in any way if you choose to file a complaint.

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Dallas, TX 75230
972-566-6300

US Dept. of Health and Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, DC 20201