PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

SPOUSE`S NAME

SPOUSE`S SOC.SEC.#

SPOUSE`S BIRTHDATE

SPOUSE`S CELL #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 10:48 AM | GENE FLANAGAN, D.D.S., P.C. | Date 6/10/2019

CORRECTED 2014

Patient Name: | Birth Date: | Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

HEIGHT?

WEIGHT?

Are you under a physician's care now? If so, provide us with name and phone number.	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head, neck or back injury or surgery?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medication containing bisphosphonates?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Local Anesthetics	☐ NSAIDS

OTHER ALLERGIES? ◯ Yes ◯ No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Hepatitis A,B or C ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Herpes ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No	Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No
Arthritis/Rheumatism ◯ Yes ◯ No	Epilepsy/Seizures or Convulsions ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Artificial Heart Valve ◯ Yes ◯ No
Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Artificial Joint/Hip or Knee Replacement ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No
Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No
Sinus Trouble /Hayfever/Allergies ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Kidney Problems/Renal Dialysis ◯ Yes ◯ No	Blood Transfusion ◯ Yes ◯ No
Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No
Liver Disease/Yellow Jaundice ◯ Yes ◯ No	Stroke ◯ Yes ◯ No	Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No
Swelling of Limbs ◯ Yes ◯ No	Cancer/Tumors/Growths ◯ Yes ◯ No	Lung Disease/ COPD ◯ Yes ◯ No	Thyroid/Parathyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis/ Tonsilsl Removed ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No
Pain in Jaw Joints ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No
Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Gout ◯ Yes ◯ No
Appendix Removed ◯ Yes ◯ No	Problems Sleeping ◯ Yes ◯ No	Anxiety/Stress Issues ◯ Yes ◯ No	Hysterectomy ◯ Yes ◯ No
Gall Bladder Removed ◯ Yes ◯ No	Shoulder Surgery ◯ Yes ◯ No	Prostate Surgery ◯ Yes ◯ No	Plastic Surgery ◯ Yes ◯ No
Shingles ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Ulcers/G.E.R.D ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

ADDITIONAL PATIENT INFORMATION Date _____

I learned of your office by: ____Referral _____
____Google ___Yahoo ____Bing ____Other Internet ____ Our Website
____1-800-DENTIST ____Exterior Sign ____ Phone Book ____Other _____

Person to contact in case of emergency:
_____ _____ (____)_____-_____ (____)_____-_____
Name Relationship Daytime Telephone# Evening Telephone#

I hereby authorize the Doctor to perform the treatment, medication and therapy that in his judgment may be indicated in connection with (name of patient) _____and further
authorize and consent that the Doctor choose and employ such assistance as he deems appropriate.

_____ _____ _____
Signature of Responsible Person Date Relationship to Patient

How do you feel about your smile?_____
_____
Are you happy with the way your teeth and gums look and feel?_____
What one thing would you change about your smile? _____
Is there anything about your previous dental experiences that you would like to tell us about? _____
_____
_____

Do you feel treatment you have had in the past was of lasting value? _____

Please circle

1. Do you have pain in the face, neck, or shoulders?.....*Yes No*
   If yes, please describe:_____
   _____
2. Do you have ringing, fullness, pain or discomfort in your ears?..... *Yes No*
3. Do you have recurring tooth or gum pain/sensitivity?..... *Yes No*
   If yes, please describe_____
4. Have you ever been injured by a blow to the jaw?..... *Yes No*
   If yes, please describe: _____
5. Do your jaw joints ever hurt or become tender when chewing, talking, yawning?..... *Yes No*
6. Do you (or have you been told you) grind or clench your teeth?..... *Yes No*
7. Do you ever notice tenderness in your jaw or have difficulty when opening your mouth?..... *Yes No*
8. Has your jaw ever gotten "stuck" or "locked" when opening or closing?..... *Yes No*
9. Have you ever been aware of any noises in one or both of your jaw joints?..... *Yes No*
   If yes, *please circle Left side (L) and/or Right side (R)……*
   Clicking (L / R)…….Popping (L / R)……."Grating" sounds\ (L / R)
10. Have you ever noticed any noises in one or both of your jaw joints that "went away?"…….. *Yes No*
    If yes, how long ago did the noises stop?_____
11. Have you ever been told by a previous dentist that you had a problem with one or both of your jaw joints?.. *Yes No*
    If yes, by whom?_____ How long ago?_____
    Were treatment recommendations made?_____
    Were you able to follow through with the treatment?_____
12. Have you ever been treated for a TMJ problem?..... *Yes No*
    If yes, by whom?_____ How long ago?_____

Please circle any treatments you have had: ***Bite Splint*** ***Physical Therapy*** ***Braces*** ***Surgery***
Bite Adjustments ***Medication*** ***Counseling*** ***Other***

FINANCIAL AND INSURANCE POLICY

1. Full payment is required for services rendered at the time of the appointment. The responsibility for payment rest with the patient/guarantor.
2. We will accept cash, check, Visa, American Express, Discover, MasterCard or Care credit (Care credit for patients without insurance only) for all services.
3. We will provide assistance to patients for filing dental insurance.
4. It is our policy to charge all patients $75.00 per hour for broken appointments when a 24 hour notice is not given. On appointments of two (2) hours or more, we require 48 hour notice to change appointment.
5. There will be a $35.00 service charge on all returned checks.
6. Account balances must be paid within thirty (30) day. Balances of 31 days are subject to interest charges of 1.5% per month.
7. When filing dental insurance and paying our office by check or credit card we will need your social security number. If you are uncomfortable giving us this information we will only accept cash as payment. Our office will assist you in filing your insurance for re-imbursement.
8. As a service to our patients we will: verify your dental coverage by telephone, inquire about ***general*** provisions of the coverage, and accept payment directly from insurance company.

By providing you with these services we are doing our best to ease the burden on your budget. However, we make no claim to know the contents of your specific insurance policy or guarantee as to the exactness of our estimates on what your insurance company will pay for specific procedures. You as the patient accepting treatment in our office and choosing to have GENE FLANAGAN, D.D.S, P.C., file you insurance, accepting payment directly from you carrier, need to understand your responsibility in this arrangement:

*You are expected to pay any deductible and co-payment at the start of treatment, not the end.
*Policies vary according to how much or how little your premiums are.
*It is impossible for this office to know your price allowance per your specific policy.
*If there is a balance after we receive all payments from your insurance carrier YOU, THE PATIENT, ARE RESPONSIBLE FOR PAYMENT OF THAT BALANCE WITHIN 30 DAYS.

I accept full responsibility for ALL charges incurred for services payable upon demand at 1827 SW Green Oaks Blvd., Ste. 169. Arlington, Tarrant County, Texas. I further agree to pay all reasonable fees incurred by GENE FLANAGAN D.D.S., P.C. in the collection of this account. I authorize release of any information relating to my insurance claims. I authorize payment directly to GENE FLANAGAN, D.D.S., P.C., of the group insurance benefits otherwise payable to me.

Signature of patient _____ Date_____

Signature of financially responsible person (if different that patient)
_____ Date_____

Business Assistant to Gene Flanagan, D.D.S., P.C. _____ Date_____

ADDITIONAL INFORMATION2-FINANCIAL & INSURANCE POLICY
Updated 01.20.16

GENE FLANAGAN D.D.S.,P.C.

1827 S.W. Green Oaks Blvd., Ste. 169

Arlington, TX 76017

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____ D.O.B. _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1.Detailed description of the information to be released: claims information, radiographs, photographs, impression(s) of teeth, etc.

2. To whom may the information be released: insurance companies, pharmacies, physicians and dentists.

3. The purpose(s) for the release : billing, insurance claim filing, prescribing medication and completing dental treatment, etc.

4. How the information is conveyed (including, but not limited to): email transmission, fax, letter, postcard, etc.

5. Expiration date or event relating to the individual or purpose for the release:

6. It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient

Relationship to Patient _____Print Name_____

ACKNOWLEDGEMENT OF RECEIPT

I ACKNOWLEDGE THAT I RECEIVED A COPY OF DR. GENE FLANAGAN'S NOTICE OF PRIVACY PRACTICES.

PATIENT'S NAME _____

SIGNATURE _____ DATE _____

GENE FLANAGAN D.D.S., P.C.

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 (GENE FLANAGAN D.D.S.,P.C.) ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Gene Flanagan D.D.S., P.C.'s Privacy Official at:Tammy Staton or Angela Flanagan at 1827 S.W. Green Oaks Blvd,. Ste 169, Arlington, TX 76017
817-468-8600 or fax 817-419-9791; Tammy.staton@aoai.com

III. 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.

IV. Last Revision Date

This Notice was last revised on January 15, 2014.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth 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. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you 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. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information 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.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, 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.

2. 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; reporting 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.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information 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.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) 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.

6. Law Enforcement Purposes. We may disclose your health information 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.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. 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.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. 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.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. 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.

VII. 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 first 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 Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. 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 your 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.

D. 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 first 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.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. 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.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. 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. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. 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 promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is [January 15, 2014].

X. How to Make Privacy Complaints

If you have any 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 on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

GENE FLANAGAN D.D.S., P.C.
1827 SW GREENOAKS BLVD. STE 169
ARLINGTON, TEXAS 76017

I _____ GIVE DR. FLANAGAN AND STAFF PERMISSION TO DISCUSS MY DENTAL CARE, INSURANCE INFORMATION, PAYMENT ARRANGEMENTS ETC

WITH_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

PATIENT SIGNATURE _____ Date _____

OFFICE STAFF SIGNATURE _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

In general, the HIPPA privacy rules gives individuals the right to request confidential communications, or that communications be made by alternative means, such as sending correspondence to the individual's place of business instead of the individual's home.

Confidential Communications

I wish to be contacted in the following manner (check all that apply):

____ Telephone, which is _____
- ____ OK to leave a message with detailed information
- ____ Leave a message with your name and call back number only

____ Written communication
- ____ OK to mail to my house
- ____ OK to fax to this number :_____

____ Work telephone, which is _____
- ____ OK to leave a message with detailed information
- ____ OK to leave a message with your name & call back number only

____ E-mail (or Text), which is _____
- ____ OK to leave a message with detailed information
- ____ OK to leave a message with your name & call back number only

_____ _____
Signature of Patient or Legal Guardian Date

For Office Use Only

We attempted to obtain written acknowledgement 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) _____