Jon M Van Slate, DDS,FAGD,LVIF, FIAPA
Augusta Drive Dental Care
1011 Augusta Dr, Suite 201
Houston, Texas 77057
(713) 783-1993
augustadrivedc@mydentalmail.com
Website: www.drvanslate.com

Patient Information Please check if patient is a minor / child ☐

First Name: ________________________________ Last Name: ______________________ Middle Initial: ______
Preferred name: ____________________________
Address: ___________________________________ City: _________________ State:________ Zip: _________
Phone / Home: ______________________ Work: _______________________Cell:_____________________

Sex: ☐ Male ☐ Female E-mail address: ____
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Birth Date: __________________Social Sec #: _______________________Driver's License/State:________________
Whom May We Thank for Referring You? ____
***Person to Contact in Case of Emergency**: ____________________________________
Phone**:______________________Relationship to the above patient** : ______________________________

Insurance Policy

Do you have dental insurance coverage? ☐ Yes ☐ No
Have you provided us with a copy of both sides of your insurance card prior to or on your appointment? ☐ Yes ☐ No

As a courtesy to our patients, we file your dental insurance claim (s) electronically and will accept assignment of benefits; only if your employer and dental insurance carrier allow a "out of network" provider to do so. In the event your insurance company does not allow assignment of benefits to the dental office, you will be responsible to pay the total cost of your services rendered on the day of treatment. If assignment of benefits is taken, your insurance company has to make payment in a reasonable amount of time. If your insurance fails to pay in a reasonable time frame or does not pay the estimated portion, you will be responsible for the balance. **Our office is only a participating provider with Aetna PPO, Humana PPO & Cigna PPO.** We accept all Dental Indemnity Plans and Dental Plans that allow you to go In or Out of Network.

Insurance Coverage

Insurance Company Name:_________________________ Phone: ______________________
Policy Holder: ___________________________ DOB: __________________
Employer:________________________________ ID/SS# ___________________________
Group#:________________________ **Medicare Advantage Policy** **Yes** ☐ **No** ☐
Relationship to Policy Holder: ___SP ___Self ___Dependent

Payment Policy & Authorization
Payment in full is expected at time of service. If you require extensive dental treatment, we have several options that may fit your needs, including Care Credit & My Smile Care Financing Plans

Please indicate how you will be paying today's services:

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

I understand that I am financially responsible for all charges whether or not paid by my dental insurance carrier. I also understand that if I have chosen to see Dr. Jon Van Slate, and his office is considered a "out of network" provider with my dental insurance plan, I am responsible for all charges/fees over what my PPO fee schedule pays. By signing below, I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the office of Jon M Van Slate, DDS/Augusta Drive Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners.
Signature:
____ Date:______________________________

# Questionnaire	Jon Van Slate, DDS, FAGD,LVIF,FIAPA Augusta Drive Dental Care

Patient Name: ______________________________________

To answer yes, please circle the words that apply to your experiences.

Have You Noticed Teeth sensitive to……?
Cold / Sweets / Pressure / Hot / Chewing / Other ______________________

Do you have ..... ?
Loose teeth / Bleeding gums / Bad Breath / Receding gums / Dry Mouth / Gum Disease

Do you have any of these jaw symptoms…..?
Jaw pain / Clicking / Popping / Locking open / Locking closed / Difficulty chewing
Tired Jaw Muscles / Accident involving your jaw / Clinching teeth / Grinding teeth / Uneven or unstable bite

Are you concerned about…..?
Yellow teeth / Crooked teeth / Chipped or Broken teeth / Spots or stained teeth
Gaps between teeth / Missing teeth / Difficulty flossing

Do you ever let these linger in your mouth….?
Hard Candy / Mints / Lemons / Pickle juice / Regular sodas / Diet Sodas / Ice Cream / Other

Do you ever ..... ?
Chew Ice or Hard Candy / Chew gum / Use your teeth as tools / Use tobacco / Floss between teeth Use toothpicks / Brush with hard or medium tooth brush / Scrub your teeth hard

In the past have you had……?
Braces / Gum Surgery / Root Canals / Tooth Whitening / Night Guard
Wisdom Teeth extracted / Other Teeth extracted / Oral Cancer / A Tooth Ache A
Broken Tooth / Deep Cleaning for Gum Disease

About your past dental care ….. _
<u>Last cleaning:</u> 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years
<u>Last x-rays:</u> 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years
<u>Last exam:</u> 3 – 4 months ago / 6 – 12 months ago / within 2 years / more than 2 years
<u>Frequency of dental visits:</u> every 6 – 12 months / sporadically / seldom / never
How often do you brush? ________________How often do you floss? __________________

Past dental experiences good and/or bad ____
____

For office use:

Main Concern: ____

Goals for keeping your teeth: ____

Are you working with a timeline: ____

I don't suppose there's anything about your teeth that you would like different: ______________________________

Patient Keeps this form

NOTICE OF PRIVACY PRACTICES for Jon M Van Slate, DDS, FAGD, LVIF, FIAPA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/15), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to others outside of our office that are involved in your dental care. We will use and disclose your health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your health information may be provided to another dental specialist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign your name. We may also call your name in the waiting room when your doctor is ready to see you. We may send you reminder postcards or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials **not** be sent to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

(Patient keeps this form)

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Appointment Policy

Your appointment time is reserved just for you. Our goal is to provide y ,
personalized, dental care. We strive to exceed your expectations. Excellence does not just happen, it is planned.

Your appointment is chosen so we can give you priority attention, and the time necessary for performing the detailed procedures with excellence. Your cooperation enables us to do this by:

- Choose your appointment time thoughtfully to avoid conflicts of your time and make your appointment a priority.
- If you have special needs regarding the selection of your appointment times please let us know so we can assist you.
- Be on time to your appointment. Depending on the procedures planned, arriving late may necessitate rescheduling the appointment or modifying the treatment that can be performed in the remaining time.
- Call us well in advance if it becomes necessary to change your appointment. Most of our patients give us at least one week's notice.
  - We are sympathetic to an occasional emergency, as they are unplanned; however same day cancellations or failing to come to your appointment is considered a broken appointment. A broken appointment is a loss to all concerned.

    - Your treatment gets delayed, as our next opening may be many weeks later.
    - Another patient who would like to be seen sooner isn't given enough notice.
    - The practice loses time and revenue
    - Our preparation for your appointment is wasted.

- We have a strict cancellation policy in force and require 24 hour notice of all cancelled dental appointments. If you miss your reserved dental appointment and have not given our office sufficient notification, you will be charged $100.00 for your missed appointment.

A pattern of broken appointments may lead to dismissal from the practice.

Patient Signature:___________________________________ Date:_______________________

Authorization to Release Information

Augusta Drive Dental Care/Jon M. Van Slate, DDS, FAGD, LVIF, FIAPA

This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself

Patient Printed Name: ___________________ ____________________

I, _________________________________, hereby authorize the use or disclosure of my protected **health information as described below:**

1. **AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION** *This form is used to obtain authorization to release information regarding you covered under the HIPAA Privacy Act to people other than yourself such as spouse, children, parents, etc..*

_____________________________________ ________________________________
Name (First, Last) Relationship

_____________________________________ ________________________________
Name (First, Last) Relationship

_____________________________________ ________________________________
Name (First, Last) Relationship

_____________________________________ ________________________________
Name (First, Last) Relationship

2. **DESCRIPTION OF INFORMATION TO BE DISCLOSED**

All past, present and future dental care information.

3. **PURPOSE OF THE USE OR DISCLOSURE**

Obtain Authorization to release information regarding to you and your dental care.

4. **VALIDITY OF AUTHORIZATION FORM**

This Authorization Form is valid for 1 year from __________________ and will expire on
Today's Date

____________________________. I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

5. **ACKNOWLEDGMENT**

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

____
Signature