

Robert E. Christensen D.D.S.
Cosmetic and General Dentistry

SECTION A: PATIENT GIVING CONSENT

Patient Name: _____
Address: _____
Telephone: _____ Email: _____
DOB: _____ SSN #: _____

SECTION B: TO THE PATIENT – READ THE FOLLOWING STATEMENTS CARE FULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practice before you decide before whether to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operation, uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice Privacy Practices. IF we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Jennifer Castaneda
Telephone: 432-684-7424
Address: 2303 West Louisiana Ave, Midland Texas 79701

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

SECTION C: SIGNATURE

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

Signature: _____ Date: _____

If this Consent is signed by a personal representative (Parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other)please Specify _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

PRIVACY PRACTICES RECEIPT / CONSENT FORM

Robert E. Christensen D.D.S. Cosmetic and General Dentistry

SECTION E: REVOCATION OF CONSENT *only if it applies to you

I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities, and healthcare operation.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to Patient: _____

SECTION F: PATIENT/RELATIVE HIPAA CONSENT * only if applies to you

I, _____, understand that by signing this Consent form, I am giving my consent to Robert E. Christensen to disclose and discuss my protected health information to carry out treatment, payment activities and health care operation with the following family member:

Name: _____

Relationship: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Compliance Officer listed on Section B.

Patient's Signature (Legal Guardian, if Patient is a minor) Date

SECTION G: RESTRICTION OF PROTECTED HEALTH INFORMATION (PHI) *only if it applies to you

I requested that Robert E. Christensen D.D.S. restrict the disclosure of my PHI to those specified below:

Name: _____

Name: _____

Signature: _____ Date: _____

If this Restriction of PHI is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____



(432) 684-7424



2303 W Louisiana Ave
Midland, TX 79701



robertchristensendds.com
office@robertchristensendds.com



Last Name: _____ First Name: _____

Please Circle Marital Status: Single Married Divorced Separated Widowed Other

Preferred Name: _____ DOB: _____

SSN: _____ DL #: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Work: _____ Home: _____

Email: _____

If Married: Spouse's Name: _____ DOB: _____ Cell #: _____

How did you hear about our practice: _____

Primary Dental Insurance Information	
Subscriber Name: _____	Employer Name: _____
Subscriber ID #: _____	Insurance Company: _____
Subscriber SSN: _____	Group #: _____
Date of Birth: _____	Insurance Phone #: _____
Relationship to Subscriber: _____	We will file Primary Dental insurance ONLY

Please present your insurance card and driver license to be scanned for our record

RESPONSIBLE PARTY (If Minor)

Last Name: _____ First: _____

Address (if different): _____ DOB: _____

City: _____ State: _____ Zip: _____

Cell: _____ Work: _____ Home: _____

Email: _____

EMERGENCY CONTACT (Not in Same Household)

Last Name: _____ First: _____

Phone #: _____

AUTHORIZATION I consent to the diagnostic procedures and dental treatment performed by my dentist, and to the release of information concerning my (or my child's) health care, advice and treatment to another dentist, or for evaluating and administering any claims for insurance benefits. I consent to the direct payment of my insurance benefits to dentist or dental group and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance.

Signature _____ Date: _____

DENTAL AND MEDICAL HEALTH HISTORY

PLEASE COMPLETE ALL INFORMATION- THANK YOU

DENTAL HISTORY		Patient Name: _____	
Reason for today's visit _____		Date of last dental visit _____	
Former dentist _____		Phone # _____ Date of last dental X-rays _____	
Please circle if you have/had:			
Bad Breath	YES/NO	Head, neck, jaw pain or aches	YES/NO
Blisters on lips or mouth	YES/NO	Lip or cheek biting	YES/NO
Burning sensation on tongue	YES/NO	Loose teeth or broken fillings	YES/NO
Chew on one side of mouth	YES/NO	Mouth breathing	YES/NO
Cigarette, pipe, or cigar smoking	YES/NO	Orthodontic treatment	YES/NO
Smokeless tobacco	YES/NO	Nitrous Oxide	YES/NO
Dry mouth	YES/NO	Sensitivity to pressure or irritants (cold, heat, sweets)	YES/NO
Food collection between teeth	YES/NO	How often do you floss? _____	Have you ever had trouble from previous Dental care? YES or NO
Clench or grind teeth	YES/NO	How often do you brush? _____	If yes, please explain: _____
Growth or sore spots in your mouth	YES/NO		
Gums swollen, tender or bleeding	YES/NO		
Have you ever been diagnosed with Periodontal Disease? YES/NO			
MEDICAL HISTORY			
Physician's Name: _____		Date of last visit: _____	
Physician's Phone #: _____		Blood Pressure: _____	
Have you had any serious illnesses or operations? YES or NO if so, please describe _____			
Have you ever had a blood transfusion? _____			
(Women) Are you pregnant? YES or NO Due Date: _____		Nursing? YES or NO	Taking Birth Control? YES or NO
Please circle if you have/ had:			
COVID-19			
Allergies, hay fever, sinusitis	YES/NO	Headaches	YES/NO
Anemia	YES/NO	Heart murmur	YES/NO
Arthritis, Rheumatism	YES/NO	Heart problems	YES/NO
Artificial heart valves	YES/NO	Hepatitis type _____	YES/NO
Artificial joints (see below)	YES/NO	Herpes	YES/NO
Asthma	YES/NO	High Blood Pressure	YES/NO
Required hospitalization	YES/NO	Any immune deficiency	YES/NO
Date of last episode _____		Jaundice	YES/NO
Have you used steroids?	YES/NO	Kidney disease	YES/NO
Blood disease, clotting disorders	YES/NO	Low Blood Pressure	YES/NO
Cancer	YES/NO	Mitral Valve Prolapse	YES/NO
Chemical dependency	YES/NO	Osteoporosis	YES/NO
Chemotherapy	YES/NO	Osteopenia	YES/NO
Circulatory problem	YES/NO	Radiation treatments	YES/NO
Cortisone treatments	YES/NO	Respiratory disease	YES/NO
Cough, persistent or bloody	YES/NO	Rheumatic fever	YES/NO
Diabetes	YES/NO	Scarlet Fever	YES/NO
Emphysema	YES/NO	Shortness of breath	YES/NO
Epilepsy	YES/NO	Sinus trouble	YES/NO
Fainting	YES/NO	Sickle cell anemia	YES/NO
Glaucoma	YES/NO	Skin rash	YES/NO
Do you need to Pre-Medicare for any dental cleanings/Treatment? (reason _____) YES/NO			
If yes to Artificial joints: _____			
Which joint(s) and date of replacement(s) _____			
AUTHORIZATION AND RELEASE			
I have read and answered the above questions to the best of my knowledge.			
Patient/Guardian Signature _____		Date _____	
Doctor Signature _____		Date _____	

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PLEASE COMPLETE ALL INFORMATION- THANK YOU

Medications

Please list ALL current medication

If you have a current medication list, we can copy that for you and attach to this form

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Cancellation, Financial and Dental Insurance Policies

Forms of payment available for treatment preformed.

Cash, debit, personal check and the following credit cards (MasterCard, Visa and Discover)

Care Credit: We offer access to an outside financing company that provides a qualifying patient with an interest free loan for dental treatment. A short application is required and once the patient is approved, it is the patient's responsibility to pay all fees incurred to the financing company.

- Payment for service is due at time treatment is render.

Initial _____

Dental Insurance:

Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Most dental insurance excludes coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on the premium paid with your policy: It coverage, exclusions, deductibles and maximums. We will recommend treatment appropriate to your dental needs, regardless of your insurance status. Our office is Out of Network with all insurance companies.

Our Courtesy service to our insured patients includes:

1. We will file the **Primary Dental insurance only**. We do not file secondary dental insurance, however we can provide any necessary claim forms and/or dental codes that may be needed.
2. Filing your claims promptly and requesting that payment be sent directly to us. Your Secondary payment will be sent directly to you after you file your claim.
3. Following American Dental Association guidelines for claims, coding and filing.
4. Estimating your benefits to best of our ability. Most insurance companies will not provide us with detailed information about your coverage, so any insurance figures we provide to you are only estimates.

Our expectations of you as the insured patient and/or owner of the policy:

1. You will pay to us all fee other than those estimated to be covered by your insurance company at the time of treatment.
2. You will assume responsibility for any amounts expected from your insurance company, but not received, within 30 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to you, and we have no leverage to obtain payment from your insurance company.
3. In the event the insurance company pay directly to you amounts that are owed to us, you agree to forward payment to us within 7 days after you receive it.

Initial _____

Appointment cancellations without Notice:

Consider your appointment with Dr. Christensen as your personal reservation. And, as with all reservation you make, (such as airlines or hotel) there must be a cancellation policy.

1. As a courtesy to you, we will make every effort to confirm your reserved appointment. But, please do not consider it our responsibility to do so. If our attempts are unsuccessful, it is still your responsibility to keep your reserved appointment or contact us at least 24 hours in advance to change or cancel your reserved appointment time.
2. All patients who fail to arrive for their reserved appointment or who cancel without 24 hour notice will be charged a missed appointment fee of \$50. Please note that this missed appointment fee is NOT covered by insurance plans, and it is your responsibility to pay it. This fee will be waived only for unforeseen circumstances at Dr. Christensen's discretions.

Initial _____

We appreciate all of our patients, and it is not our intent to offend anyone. With your compliance, we will be more able to keep our schedule "on time" accommodates any emergencies, and help patients who are on our waiting list seek necessary treatment promptly. We thank you for your understanding in this matter.

I hereby authorize Dr. Robert E. Christensen, D.D.S. to release to my insurance company and information acquired in the course of my dental care. I authorize benefits to be paid directly to Robert E. Christensen, D.D.S. I understand I am Responsible for all fee incurred, regardless of status of insurance and that payment is due at time of service rendered.

Responsible Party: _____

Signature: _____ Date: _____

Witness (Staff Member): _____ Date: _____