cws family dentistry
CHRISTI WEAVER SHEPARD
(501) 228-4900

New Patient Form

4200 N. Rodney Parham Rd., #200
Little Rock, AR 72212
www.cwsfamilydentistry.com

First Name: Last Name: Middle Initial:

Patient is: ❍ Policy Holder ❍ Responsible Party Preferred Name:

Referred by: Referral Type:

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address: ❍ I would like to receive correspondence via ❍ email ❍ text.

Birth Date: Age: Social Security: Driver's License:

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

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired

Student Status: ❍ Full Time ❍ Part Time

Emergency Contact:

Contact #: Relationship:

Pref. Pharmacy:

Comments:

Responsible Party
(if someone other than the patient)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security: Driver's License:

❍ Responsible Party is also a Policy Holder ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security/ID:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Rem. Benefits: **Rem Deductible:**

Medical Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Rem. Benefits: **Rem Deductible:**

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Medical History

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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, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If yes, please explain: _____

Do you need to premed? ❍ Yes ❍ No If yes, what for? _____

Do you snore? ❍ Yes ❍ No Have you been diagnosed with sleep apnea? ❍ Yes ❍ No If yes, are you a CPAP user? ❍ Yes ❍ No How Long? _____ Do you like it?_____ Date of last sleep study_____ Sleep Physician_____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No If yes, please explain: _____

Are you on a special diet? ❍ Yes ❍ No If yes, please explain: _____

Do you use tobacco? ❍ Yes ❍ No If yes, please explain: _____

Do you use controlled substances? ❍ Yes ❍ No If yes, please explain: _____

Who is your primary care physcian? _____ Phone Number _____

Women: Are You

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking Oral Contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

If pregnant, number of weeks? _____

Allergies:

Are you allergic to any of the following: ❍ Asprin ❍ Penicillin ❍ Codeine ❍ Acrylic ❍ Metal ❍ Latex ❍ Local Anesthetics ❍ Other: _____

If yes, please explain: _____

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

AIDS/HIV Positive ❍ Yes ❍ No	Cortisone Medicine ❍ Yes ❍ No	Hemophilia ❍ Yes ❍ No	Renal Dialysis ❍ Yes ❍ No
Alzheimer's Disease ❍ Yes ❍ No	Diabetes ❍ Yes ❍ No	Hepatitis A ❍ Yes ❍ No	Rheumatic Fever ❍ Yes ❍ No
Anaphylaxis ❍ Yes ❍ No	Drug Addiction ❍ Yes ❍ No	Hepatitis B or C ❍ Yes ❍ No	Rheumatism ❍ Yes ❍ No
Anemia ❍ Yes ❍ No	Easily Winded ❍ Yes ❍ No	Herpes ❍ Yes ❍ No	Scarlet Fever ❍ Yes ❍ No
Angina ❍ Yes ❍ No	Emphysema ❍ Yes ❍ No	High Blood Pressure ❍ Yes ❍ No	Shingles ❍ Yes ❍ No
Arthritis/Gout ❍ Yes ❍ No	Epilepsy or Seizures ❍ Yes ❍ No	Hives or Rash ❍ Yes ❍ No	Sickle Cell Disease ❍ Yes ❍ No
Artificial Heart Valve ❍ Yes ❍ No	Excessive Bleeding ❍ Yes ❍ No	Hypoglycemia ❍ Yes ❍ No	Sinus Trouble ❍ Yes ❍ No
Artificial Joint ❍ Yes ❍ No	Excessive Thirst ❍ Yes ❍ No	Irregular Heartbeat ❍ Yes ❍ No	Spina Bifida ❍ Yes ❍ No
Asthma ❍ Yes ❍ No	Fainting Spells/Dizziness ❍ Yes ❍ No	Kidney Problems ❍ Yes ❍ No	Stomach/Intestinal Disease ❍ Yes ❍ No
Blood Disease ❍ Yes ❍ No	Frequent Cough ❍ Yes ❍ No	Leukemia ❍ Yes ❍ No	Stroke ❍ Yes ❍ No
Blood Transfusion ❍ Yes ❍ No	Frequent Diarrhea ❍ Yes ❍ No	Liver Disease ❍ Yes ❍ No	Swelling of Limbs ❍ Yes ❍ No
Breathing Problems ❍ Yes ❍ No	Frequent Headaches ❍ Yes ❍ No	Low Blood Pressure ❍ Yes ❍ No	Thyroid Disease ❍ Yes ❍ No
Bruise Easily ❍ Yes ❍ No	Genital Herpes ❍ Yes ❍ No	Lung Disease ❍ Yes ❍ No	Tonsillitis ❍ Yes ❍ No
Cancer ❍ Yes ❍ No	Glaucoma ❍ Yes ❍ No	Mitral Valve Prolapse ❍ Yes ❍ No	Tuberculosis ❍ Yes ❍ No
Chemotherapy ❍ Yes ❍ No	Hay Fever ❍ Yes ❍ No	Pain in Jaw Joints ❍ Yes ❍ No	Tumors or Growths ❍ Yes ❍ No
Chest Pains ❍ Yes ❍ No	Heart Attack/Failure ❍ Yes ❍ No	Parathyroid Disease ❍ Yes ❍ No	Ulcers ❍ Yes ❍ No
Cold Sores/Fever Blisters ❍ Yes ❍ No	Heart Murmur ❍ Yes ❍ No	Psychiatric Care ❍ Yes ❍ No	Venereal Disease ❍ Yes ❍ No
Congenital Heart Disorder ❍ Yes ❍ No	Heart Pacemaker ❍ Yes ❍ No	Radiation Treatments ❍ Yes ❍ No	Yellow Jaundice ❍ Yes ❍ No
Convulsions ❍ Yes ❍ No	Heart Trouble/Disease ❍ Yes ❍ No	Recent Weight Loss ❍ Yes ❍ No	

Comments: _____

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 Date

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Privacy Practices

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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:

Federal and state law requires us to maintain the privacy of your health information. That law also requires us 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 we describe in this notice while it is in effect. This notice takes effect April 14, 2003 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 applicable law permits the changes. 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 make changes to 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 health care operations. For example:

Treatment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations included quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and proven performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: 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 uses 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 may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgement of whether the disclosure would be in your best interest. We may use our professional judgement 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. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

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

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employees regarding work-related illness or injury;
- To report adult abuse, neglect or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and as
- Authorized by state worker's compensation laws.

Patients 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 request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may - but are not required to - 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 more information about fees.

Disclosure Accounting: 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). Any agreement we may make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation of how you will handle payment 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 we should amend the information. We may deny your request under certain circumstances.

Question and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- **We may have violated your privacy rights.**
- **We made an incorrect decision about access to your health information.**
- **Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or**
- **We should communicate with you by alternative means or at alternative locations.**

You may contact us using the information listed below. 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.

Christi Weaver Shepard, DDS, PA
4200 N. Rodney Parham Rd., #200
Little Rock, AR 72212

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____, have received a copy of the **Notice of Privacy Practices of this office.**
(NAME, PLEASE PRINT)

_____ _____
Signature of Patient Date

Please Note: It is your right to refuse to sign this acknowledgement.

I allow my account to be discussed with _____. Relationship_____

Signature_____

Office Use Only:

We tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

❍ An emergency prevented us from obtaining acknowledgement.
❍ A communication barrier prevented us from obtaining acknowledgement
❍ The individual was unwilling to sign
❍ Other:

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Insurance Information Agreement

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Dental Insurance is one of the most beneficial and most misunderstood areas in dental treatment today. This explanation will attempt to clear up many common misconceptions about dental insurance. Dental Insurance is a contract between the EMPLOYER and the PATIENT. It has NO CONNECTION at all to the dentist who is providing the dental treatment. The extent of coverage varies greatly from company to company, and sometimes even within a company. It has absolutely NOTHING to do with the level of service provided by the dentist and the fee charged, but with the level of coverage negotiated by your employer. For this reason estimates of a patient's portion for any given procedure may not be exact because often there are variations in the amount that the insurance company is willing to pay based on your particular policy. For example, if a dentist charges $100 for a filling and the coverage is listed at 80%, the patient may assume that their insurance company will pay $80 toward this filling. However, if your policy only ALLOWS $90 for a filling and your policy ALLOWS 80% coverage of the amount, then the insurance company will ACTUALLY pay $72 toward the service, not $80. So instead of the patient paying $20 out of pocket, they will actually be paying $28 (the remainder of the dentist's $100 fee). This is a common point of confusion, because the percentages given by the insurance company are not of the DENTIST'S FEE but are percentages of ALLOWANCE of the insurance policy. Our policy on dental insurance is as follows: We make every effort possible to assist you with your particular insurance coverage. Although it is not required, we will prepare and submit your insurance forms free of charge as a courtesy. We will also provide an estimate that will show expected insurance reimbursement and patient share for each procedure. Our office can only ESTIMATE what the insurance company will cover because most insurance companies' will not disclose their exact ALLOWANCES. The patient's estimated share will be due at the time of treatment. Should our estimate of the patient's share be too high, a credit will be issued to the account or refunded to the patient if requested. Likewise, if the estimate was too low, the remainder of the balance will be due at the time that the insurance payment is received. Should no insurance payment be made within 60 days of submitted claim, the fee will become the sole responsibility of the patient who may choose to take it up with their insurance company at that time. I understand that any services provided by the office that my insurance deems not necessary are my financial responsibilities. Thank you for your cooperation in this matter.

_____ _____

Patient's Signature/Responsible Party Date