Dr. Marisol Trautmann
2450 East Prosper Trail Suite 30
Prosper, TX 75078

PATIENT INFORMATION

PATIENT NAME: _____TODAY'S DATE_____

HOME ADDRESS: _____CITY_____STATE____ZIP_____

EMAIL ADDRESS_____HOME PH_____MOBILE_____

PREFERRED METHOD OF APPOINTMENT CONFIRMATION: EMAIL TEXT PHONE (CIRCLE ALL THAT APPLY)

SSN: _____ D/L #: _____ DOB: _____

MARITAL STATUS: _____

OCCUPATION: _____ EMPLOYER NAME: _____

BUSINESS ADDRESS: _____CITY: _____ PHONE: _____

SPOUSE'S NAME: _____ SSN: _____ PHONE: _____

SPOUSE'S OCCUPATION: _____ EMPLOYER: _____

PERSON TO CONTACT IN AN EMERGENCY:

NAME: _____RELATION: _____

PHONE NUMBER: _____

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT: _____

PHONE NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

REASON FOR THIS VISIT? _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's ID or SSN: _____ Policy Holder's DOB: _____

Insurance Company Name: _____

Phone Number: _____ Group Number:_____

Claims Mailing Address: _____
P.O. Box or Street

_____
City State Zip Code

PROSPER
Dental Health
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HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS PRIVATE AND CONFIDENTIAL.

DENTAL HEALTH HISTORY

Your Previous Dentist: _____ City: _____ how long were you a patient? _____ Date of Last visit _____ Date of last cleaning _____Last x-rays_____

Check any of the following that you currently have or have had:

__Mouth Discomfort	__Grind or Clench your teeth	__Immediate relatives with loss of teeth
__Previous Periodontal Treatment	__Clicking, Popping or pain in jaw	__Gum Abscesses
__Orthodontic Treatment	__Bad Dental Experience	__Fear of dental Treatment
__Wake with Sore Jaw	__Mouth Odor or Bad Taste	__Cold sore or Fever Blisters
__Other Oral Lesions	__Sensitive Teeth (hot, cold, sweets)	__Gums Bleed when Brushing
__Loose or Shifting Teeth	__Trouble in Chewing or Speaking	__Bruise Easily

__Complications with or Following Previous Dental or Oral Surgical Treatment

MEDICAL HEALTH HISTORY

1. How would you describe your current health? Excellent Good Fair Poor
2. Please list your current physicians
   (a) _____ Type_____ How long_____
   (b) _____ Type_____ How long_____
3. Date of last complete physical exam _____ Purpose _____
   Findings _____

	Circle "YES" or "NO"	Explain
1. Are you aware of any changes in your general health in the last year?	No Yes	_____
2. Have you been hospitalized for illness or surgery in the last 2 years?	No Yes	_____
3. Have you been under the care of a physician in the last 2 years?	No Yes	_____
4. Have you ever had excessive bleeding that required treatment?	No Yes	_____
5. Is there any history of diabetes in your family?	No Yes	_____
6. Are you required to restrict your activity in any way?	No Yes	_____
7. Are you on a special or restricted diet of any kind?	No Yes	_____
8. Do you smoke?	No Yes	How much? _____ How Long? _____
9. Do you use smokeless tobacco?	No Yes	How Much? _____ How Long? _____
10. Do you snore?	No Yes	_____
11. When you wake in the morning, do you feel rested?	No Yes	_____
12. Do you fatigue easily as the day progresses?	No Yes	_____
13. What is your neck size?	Inches	_____

14. List any medications you are currently taking, please include any over the counter. _____
    _____
    _____

Please circle any of the following you are allergic to:

Penicillin	Viramidine	Novocain	Tylenol	Codeine	Other _____
Erythromycin	Sulfa Drugs	Carbocyanine	Aspirin	Ibuprofen	_____
Tetracycline	Keflex	Xylocaine	Anesthetics	Latex	_____

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Indicate which of the following you currently have or have had. You must circle each response individually: "YES" or "NO"

Heart Trouble	NO	YES	Anemia	NO	YES
Heart attack or disease	NO	YES	Artificial Joint	NO	YES
Angina	NO	YES	Kidney, Bladder Trouble	NO	YES
High Blood Pressure	NO	YES	Thyroid Disease	NO	YES
Low Blood Pressure	NO	YES	Emphysema	NO	YES
Heart Murmur	NO	YES	Persistent Cough	NO	YES
Rheumatic Fever	NO	YES	Tuberculosis	NO	YES
Congenital Heart Lesions	NO	YES	Asthma	NO	YES
Artificial Heart Valve	NO	YES	Hay Fever	NO	YES
Scarlet Fever	NO	YES	Sinus Trouble	NO	YES
Heart Pacemaker	NO	YES	Allergies or Hives	NO	YES
Heart Surgery	NO	YES	Diabetes	NO	YES
Shortness of Breath upon Mild Exertion	NO	YES	Frequent Thirst and/or Urination	NO	YES
Require more than 2 pillows to sleep	NO	YES	Stroke	NO	YES
Ankles Swell	NO	YES	Jaundice	NO	YES
Epilepsy or Seizures	NO	YES	A.I.D.S	NO	YES
Frequent Headaches	NO	YES	HIV	NO	YES
Fainting or Dizzy Spells	NO	YES	Drug or Alcohol Addiction	NO	YES
Cancer or Tumors	NO	YES	Blood Transfusions	NO	YES
Radiation Treatment	NO	YES	Hemophilia	NO	YES
Chemotherapy	NO	YES	Ulcers	NO	YES
Arthritis/ Rheumatism	NO	YES	Bisphosphonate Treatment	NO	YES
Hepatitis	NO	YES	Are you a Nervous Person	NO	YES
Liver Disease	NO	YES	Psychiatric Care	NO	YES
Glaucoma	NO	YES	Unintentional Weight loss or gain	NO	YES
Contact Lenses	NO	YES			
Other	NO	YES			

List any ADDITIONAL MEDICAL CONDITIONS:

_____

_____

To the best of my knowledge, all the preceding answers are correct and true. If I ever have any changes in my health or if my medications change, I will inform the doctor at or before my next appointment without fail.

Patient Signature **DATE**

Clinician Signature **DATE**

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PATIENT QUESTIONNAIRE

Do you like the way your teeth look? Yes No

Explain _____

Are you happy with the color of your teeth? Yes No

Explain _____

Would you like your teeth to be straighter? Yes No

Explain _____

Do you have spaces between your teeth you would like closed? Yes No

Explain _____

Do you have missing teeth you would like to replace? Yes No

Explain _____

Do you have old silver fillings you would like replaced with tooth colored fillings? Yes No

Explain _____

If you could change anything about your smile, what would you change? _____

_____

Do you snore, or has anyone ever told you that you snore? Yes No

Has anyone ever told you that you stop breathing in the night? Yes No

Do you awake refreshed in the morning? Yes No

Have you ever had a sleep study? Yes No

Have you ever or do you now use a CPAP machine? Yes No

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DENTAL INSURANCE AND FINANCIAL POLICY

Our office does not contract with any insurance company as a provider, regardless of your diagnosis, nor do we have any specific information regarding your insurance benefits. As a courtesy, we will assist you in filing electronic claims to your insurance provider for your "out of network" benefits. **We do not guarantee any payment from your insurance company.**

We ask that our patients secure financial arrangements prior to their scheduled appointment. **If you use a dental insurance policy to assist in your payment, we require a 60% down payment for all services except cleanings, periodic exams, and periodic radiographs.** If your insurance company reimburses us more than your remaining balance, we will mail you a reimbursement check. **If your insurance company reimburses us less than your remaining balance, you will be responsible for the remaining amount.** It may take up to 45 business days for us to receive a check from your insurance company.

We offer options regarding financial arrangements for treatment. Payments may be made in full by cash, check, Visa, MasterCard, American Express or Discover. If necessary, extended payments can be arranged by using Care Credit, an outside lending source. If outside financing is used, the entire fee will be applied to your Care Credit card and your insurance reimbursement will be mailed directly to you.

If you have questions regarding your account, please contact our office at 972-347-2233. **Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.**

By signing below, I hereby certify that I have read and understand the above statements.

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE — DATE

CREDIT CARD AUTHORIZATION
"Signature on File"

If you would like Prosper Dental Health to keep your Credit Card on file, please fill out the following:

Prosper Dental is authorized to keep my signature on file and issue a charge memo to my credit card for any outstanding balance. Prosper Dental Health will contact me **before** any charges are made and any agreed upon balance will be directly applied to this credit card.

Patient Name: _____

Additional family members authorized to use this credit card: _____

Card Type: (circle one) Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

Name as it appears on card: _____

_____ _____

PATIENT SIGNATURE — DATE

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GENERAL CONSENT

I authorize Dr. Marisol Trautmann, and/or her designated staff to perform such diagnostic aids deemed appropriate to make a proper and thorough diagnosis of my dental needs. Upon such diagnosis I authorize Dr. Trautmann, and/or her designated staff to perform all recommended treatments, procedures, and medication administrations as prescribed by the dentist and agreed upon by me, or my legal guardian. I understand that during treatment it may be necessary to change or add procedures to my treatment plan because of conditions found while treating the teeth that were not discovered during examination. I give my permission to Dr. Trautmann to make all changes and additions to my treatment plan, as necessary.

Medical History: I have disclosed all my medical history including, but not limited to, any and all drugs and medications that I am currently taking and have taken within the last 72 hours. I have also disclosed all medications, foods, and other substances to which I am allergic.

Radiographs: I understand that Dr. Trautmann, and/or her staff may need to take and evaluate x-rays to aid with proper diagnosis.

Local Anesthesia: I understand that local anesthesia is often used during dental treatment. I further understand that the risks of local anesthesia include, but are not limited to dizziness, nausea, vomiting, increases or decreases in heart rate, allergic reactions that may require medical management or hospitalization, restricted mouth opening, accidental self-injury from biting numb cheeks, lips, or tongue, and/or temporary or permanent numbness, pain, or changed feelings in the teeth, gums, lip, chin and/or tongue (including possible loss of taste).

No Guarantee: I understand that dentistry is not an exact science and that, therefore, dentists cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized.

Insurance: I assign all dental insurance benefits to which I am entitled to the extent permitted under my insurance policy to Prosper Dental Health and authorize Prosper Dental Health to submit claim forms and receive payments directly with the notation “signature on file”. I authorize release of my treatment records, x-rays, and other matters in my file deemed pertinent to my insurance as requested. I agree to be responsible for payment of all services rendered by Prosper Dental Health on my behalf or to my dependents. I agree that I am responsible for all unpaid claims.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct.

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE, OR LEGAL GUARDIAN’S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

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HIPAA CONSENT AND AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: I have been provided with and understand Prosper Dental Health's Notice of Privacy Practices. I understand I have the right to request a copy of Prosper Dental Health's Notice of Privacy Practices at any time. Prosper Dental Health may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations as described in Prosper Dental Health's Notice of Privacy Practices.

I give consent to Prosper Dental Health to call me, leave voicemails, speak directly to family members answering my phone, and send mail and email to the addresses I provided, in reference to any items that assist the practice in carrying out treatment, payment, or operations, such as appointment reminders, billing information, insurance items, and any other information pertaining to my oral health.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Prosper Dental Health is required to agree to the requested restrictions if they are reasonable. The restrictions I request are:

_____

_____

_____

I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance thereon.

By signing below, I hereby certify that I have read and understand the above statements and those statements are true and correct.

_____
PATIENT NAME

_____ _____
PATIENT SIGNATURE, OR LEGAL GUARDIAN'S SIGNATURE IF PATIENT IS YOUNGER THAN 18 YEARS OF AGE

DATE

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NOTICE OF PRIVACY PRACTICES

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 04/13/2003 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 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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.

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 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 is 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 interferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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.

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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 the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized 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 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 $25 up to 25 pages and $0.15 for every page after

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 your 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 retain the right to 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.

QUESTION AND COMPLAINTS

If you would like 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.

Contact Officer: Prosper Dental Health
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972-632-7575