Canyon Creek Dentistry

Kinnari Prajapati, D.D.S.

1618 Canyon Creek Drive, Ste. 110

254-771-5900

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand Canyon Creek Dentistry has the right to change its Notice of Privacy Practices from time to time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I have received the Health Insurance Portability and Accountability Act (HIPAA) information that was provided by Canyon Creek Dentistry.

Patient Name (please print):_____

Patient/Guardian Signature: _____ Date:_____

Staff Will Fill Out This Section If Patient's Signature Is Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt of our Notice of Privacy Practices**, but it could not be obtained for the following reasons:

_____Patient refuses to sign.

_____Emergency situation kept us from obtaining the patient's signature.

_____Language barriers kept us from obtaining the patient's signature.

____Other_____

Canyon Creek Dentistry

1618 Canyon Creek Dr. Ste.110, Temple, TX 76502

Adult History and Health Questionnaire

Date:_____

Patient's Name: _____SSN#:_____ Preferred Language:_____

DOB: _____ Age:_____ Gender: M or F Marital Status: _____ Race:_____

Address: _____Apt#_____ City, State:_____ ZIP:_____

Home#:_____Cell#:_____Work#:_____

Email Address: _____

Employer: _____ Occupation: _____

Primary Dental Insurance Company:_____Group#:_____

Insured Name: _____ Insured SSN#:_____

Secondary Dental Insurance Company:_____Group#:_____

Insured Name: _____ Insured SSN#:_____

How did you hear about us? Insurance Co. Internet Phonebook Friend/Family Current Patient Doctor's Office

Whom may we thank for the referral: Name: _____Number_____

CONSENT TO TREATMENT: By my signature, I authorize Canyon Creek Dentistry to perform procedures including, but not limited to, dental exam, prophylaxis (cleaning), taking radiographs or photographs, administering anesthetics and/or medications, restoring (filling) teeth, placing sealants, placing crowns, extracting (removing) teeth, endodontics (root canal) therapy, and other procedures he/she may deem necessary for my care. I give permission to have blood drawn for testing in the event of a needle stick or puncture wound to the provider during the course of the treatment. Radiographs, photographs and other records will remain the property of Canyon Creek Dentistry.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services are charged directly to the patient. We will file all necessary forms or reports to your insurance company. We do not render our services on the basis that insurance companies will pay our fees. By signing below, you authorize the release of any information relating to your dental work to your insurance company. Also, you authorize the payment of the dental benefits otherwise payable to you directly to Canyon Creek Dentistry. ***Patients are responsible for any fees the insurance company does not cover.***

PAYMENT POLICY: Payments for the professional services must be made at the time service is rendered unless prior arrangements are made. I understand and agree that I am ultimately responsible for the balance on my account. If I fail to meet the arrangements that have been provided, I understand that my account will be turned over to a third party for collections as provided by the law. ***A $25.00 fee will be assessed on scheduled appointments not cancelled with a 48 hour notice.***

Date: _____ Patient: _____

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Adult Medical and Dental History

Name: _____ DOB: _____

DENTAL HISTORY

Reason for the visit: _____

Are you having any dental discomfort? _____ Date of last dental visit: _____

Have you had any negative dental experiences? _____

Have you had any injuries to your teeth or face? _____

Do any family members have missing teeth? _____ History of decay? _____

Do you have oral habits? Circle all that apply. Grinding Smoking Dip/Snuff Snoring Bleeding Gums Halitosis
Other: _____

MEDICAL HISTORY

List of current medications: _____

Have you had any hospitalizations, serious illness, or operations in the last 6 months?_____

Primary Care Doctor's Name: _____Number: _____

Please check yes or no next to the following:

Yes	No		Yes	No	
__	__	Asthma	__	__	Rheumatic Fever
__	__	Respiratory Problems	__	__	Cerebral Palsy
__	__	Stroke/Heart Attack (circle that applies)	__	__	Epilepsy/Seizure Disorder
__	__	High Blood Pressure	__	__	Brain Injury
__	__	Heart Murmur	__	__	Autism
__	__	Diabetes I or II	__	__	ADD/ADHD
__	__	Renal/Kidney Disease	__	__	Mental Disorder
__	__	Hepatitis/Liver Disease	__	__	Developmental Delay
__	__	Sickle Cell Anemia	__	__	HIV/AIDS Positive
__	__	Bleeding Disorder	__	__	Pregnant: # of months: _____
__	__	Cancer/Chemotherapy	Other:_____		

Allergies:

Yes	No		Yes	No	
__	__	Penicillin/Amoxicillin	__	__	Latex
__	__	Tylenol	__	__	Local Anesthetics
__	__	NSAIDS: Ibuprofen, Motrin	__	__	Benzodiazepine
__	__	Codeine	__	__	Milk/Dairy Products/Eggs
__	__	Aspirin	Other: _____		
__	__	Sulfonamides			

If yes to any of the above, what kind of reaction is it:_____
Is there anything about you or your health we should know to provide you with the best care?
_____

CONSENT FOR TREATMENT

The undersigned hereby authorizes Dr. Kinnari Prajapati and/or her auxiliary personnel to perform the necessary dental services and those methods she deems appropriate for my care. This consent shall remain in full force and effect until cancelled by either party.

Date: _____ **Signed:_____**
Patient

Date: _____ **Signed:_____**
Doctor