Ponder Family Dental

Tyler P. Myser, DDS

Welcome to our office!

To assist us in serving you, please complete the following confidential forms.

How did you hear about our offce?

☐  **Google**

☐  **Facebook**

☐  **Internet**

☐  **Drive By**

☐ 

Dental Insurance

☐  **Twitter**

☐  **Family/Friends:** _____

☐  **Other:** _____

_____

Your Name

Ponder Family Dental

Tyler P. Myser, DDS

PATIENT INFORMATION

Patient's Name_____ Birthdate_____ SS#_____

Marital Status_____ Driver's License #_____ State_____

Home Phone_____ Work Phone_____ Cell Phone_____

Mailing address_____ City_____ State_____ Zip_____

Email_____

Employer_____ Occupation_____

Whom may we thank for referring you to our office? _____

Is an immediate family member a patient here? ☐YES ☐NO *If yes, Name:_____

May we contact you regarding upcoming appointments, reminders, or office specials via Email and/or Text Message? ☐YES ☐NO

INSURANCE INFORMATION: ☐ Not covered by dental insurance.

Insured Name_____ Insured Date of Birth_____

Insured Employer_____

Insured ID or Social Security # _____ Dental Insurance Co_____

Group Number_____ Phone Number_____

RESPONSIBLE PARTY INFORMATION: ☐Self ☐Other

Name_____ Relationship To Patient_____

Birthdate_____ Social Security #_____ Drivers License #_____

Address_____ City_____ State_____ Zip _____

☐Home Phone_____ ☐Work Phone_____ ☐Cell Phone_____

**Please check your preferred phone number above.

EMERGENCY CONTACT INFORMATION:

Name of nearest relative not living with you_____

Home Phone_____ Cell Phone_____

Address_____ City_____ Zip_____ State_____

Patient's Signature_____ Date: _____

Parent/Guardian Name (if patient is a minor): _____ Relationship to Patient: _____

Ponder Family Dental

Tyler P. Myser, DDS

MEDICAL HISTORY (Page 1)

Patient Name:_____ **Date:**_____

Do you currently have OR have you previously had any of the following conditions?

AIDS/HIV Positive	( ) YES	( ) NO
Anemia	( ) YES	( ) NO
Angina Pectoris	( ) YES	( ) NO
Arthritis	( ) YES	( ) NO
Artificial Joint or Heart Valve	( ) YES	( ) NO
Asthma	( ) YES	( ) NO
Blood Clotting Disorder	( ) YES	( ) NO
High Blood Pressure	( ) YES	( ) NO
Low Blood Pressure	( ) YES	( ) NO
Blood Transfusion	( ) YES	( ) NO
Bruise Easily	( ) YES	( ) NO
Cancer	( ) YES	( ) NO
Chemotherapy	( ) YES	( ) NO
Cold Sores/Fever Blisters	( ) YES	( ) NO
Congenital Heart Defects	( ) YES	( ) NO
Diabetes	( ) YES	( ) NO
Dizziness/Fainting	( ) YES	( ) NO
Emphysema	( ) YES	( ) NO
Epilepsy	( ) YES	( ) NO
Glaucoma	( ) YES	( ) NO
Heart Attack	( ) YES	( ) NO
Heart Disease	( ) YES	( ) NO
Heart Murmur	( ) YES	( ) NO
Heart Surgery	( ) YES	( ) NO
Hepatitis A	( ) YES	( ) NO
Hepatitis B	( ) YES	( ) NO
Hepatitis C	( ) YES	( ) NO
High Cholesterol	( ) YES	( ) NO
Kidney Problems	( ) YES	( ) NO
Liver Disease	( ) YES	( ) NO
Migraines	( ) YES	( ) NO
Mitral Valve Prolapse	( ) YES	( ) NO
Pacemaker	( ) YES	( ) NO
Psychiatric Treatment	( ) YES	( ) NO
Radiation Treatment	( ) YES	( ) NO
Rheumatic Fever	( ) YES	( ) NO
Scarlet Fever	( ) YES	( ) NO
Seizures	( ) YES	( ) NO
Sickle Cell Disease/Trait	( ) YES	( ) NO
Sinus Problems	( ) YES	( ) NO
Sleep Apnea	( ) YES	( ) NO
Stroke	( ) YES	( ) NO
STD or VD	( ) YES	( ) NO
Thyroid Disease	( ) YES	( ) NO
TMJ Disorder	( ) YES	( ) NO
Tuberculosis	( ) YES	( ) NO
Ulcers/Colitis	( ) YES	( ) NO

Are you allergic to, or have you had an adverse reaction to any of the following?

( ) Latex Materials
( ) Adhesive Tape
( ) Barbiturates / Sedatives
( ) Local Anesthetic
( ) Other:_____
( ) No Known Drug Allergies
( ) Sulfa Drugs
( ) Aspirin
( ) Penicillin
( ) Codeine / Narcotics

Please list ALL current medications/supplements you are taking (including over the counter):

Medication Name	*Dosage*

Please answer the following questions:

When was your last dental exam? _____

Do you smoke or use chewing tobacco?	( ) YES	( ) NO
Do you grind your teeth?	( ) YES	( ) NO
Do you snore?	( ) YES	( ) NO
Do you currently wear an occlusal guard?	( ) YES	( ) NO
Have you ever had orthodontic treatment?	( ) YES	( ) NO
Have you ever had scaling and root planing ("a deeper than routine cleaning") that required numbing of the teeth or gums?	( ) YES	( ) NO

Do you currently have any of the following?

( ) Bad Breath
( ) Bleeding/Swollen Gums
( ) Broken Teeth
( ) Difficulty opening or closing
( ) Dry Mouth
( ) Jaw Pain
( ) Loose Teeth
( ) Frequent Headaches

Sensitivity to: ( ) Cold ( ) Heat ( ) Sweets ( ) Pressure

Women:

( ) Currently Pregnant: _____ (weeks/months)
( ) Taking Hormones or Contraceptives
( ) Breastfeeding
( ) May be Pregnant

Ponder Family Dental
Tyler P. Myser, DDS

MEDICAL HISTORY (Page 2)

Have you been hospitalized or had a serious operation or illness within the last five years? ( ) YES ( ) NO

If yes, please explain: _____

_____

Do you have any disease, condition, or problem not listed? ( ) YES ( ) NO

If yes, please explain: _____

_____

Do you need premedication before treatment? ( ) YES ( ) NO

Reason: _____ Type: _____ Dosage: _____

Are you now under the care of a physician? ( ) YES ( ) NO

Name of your Physician:_____ Phone number: _____

Is there anything about your smile that you are interested in changing? ( ) YES ( ) NO

If yes, please explain: _____

_____

Are you interested in learning any current cosmetic improvements such as whitening, or veneers? ( ) YES ( ) NO

Do you prefer to use nitrous oxide sedation ("laughing gas") during dental procedures? ( ) YES ( ) NO

CONSENT: I, _____, authorize Ponder Family Dental PLLC to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my (the patient's) dental needs. Your photos and x-rays are part of your diagnostic and clinical record. These images may be used for diagnosis, documentation, reference, teaching, and research publication. Some cases that present exceptional results or interesting situations may be utilized for demonstration, education or advertising to potential and existing patients in our office either in print media, social media, television, on digital media and on our webpage. In some instances, you may be recognizable in some of these images. By signing this form, you are authorizing us and releasing us from any liability resulting from the use/release of such images. I also consent to and authorize Ponder Family Dental PLLC to perform any and all forms of treatment, preventative treatment, administration of medication and anesthetics, as well as therapy that may be indicated for the Patient and further authorize and consent that Ponder Family Dental PLLC choose and employ such assistance as they deem fit.

Patient's Printed Name: _____ Date: _____

Patient's Signature: _____ Witness:_____

Parent/Guardian Name (if patient is a minor): _____ Relationship to Patient: _____

Ponder Family Dental
Tyler P. Myser, DDS

OFFICE POLICIES

CANCELLATION AND BROKEN APPOINTMENT POLICY

A reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving their dental care in a timely fashion.

Those who fail to keep their scheduled appointments should not penalize the Dentist, our staff, and mainly our other patients. Our dental policy stipulates that failure to give sufficient notice to keep a scheduled appointment will result in a fee being charged. That charge is in accordance with our dental office's broken appointment policy for all of our patients. The patient or the patient's responsible party is responsible for the payment of the charge.

- Cancellation or rescheduling of an appointment **with 48 hours notice or more** notification will result in **no charge** to your patient account.

- **Cancellation, rescheduling, or failure to show-up for a scheduled appointment with less than 24 hour notice will be charged $50 per appointment.**

Every effort is made to contact our patients to confirm their scheduled appointment. Our staff will contact you 2 days prior to your scheduled appointment to confirm with you. Please understand that this is a courtesy confirmation. DO NOT DEPEND ON THIS. If we are unable to reach you, your appointment card will serve as your confirmation of the appointment and implies your obligation to be present.

MINORS

Please be advised that we will not treat any minor children unless a parent or legal guardian signs an informed written consent **AND** a parent or legal guardian remains on the premises for the duration of the appointment. If anyone other than a parent or legal guardian brings a minor to their appointment, we must have prior written authorization signed by the parent or guardian and witnessed by a staff member before we will proceed with authorized procedures.

FINANCIAL POLICY

We accept cash, Care Credit, and most major credit cards (Visa, MasterCard, American Express, Discover, etc.).

WE DO NOT ACCEPT CHECKS.

Although we do accept the assignment of most insurance companies, your insurance is an agreement between you and your insurance company. We will do our best to see that you receive your full benefits. As a complimentary service to you, we will bill insurance companies. We allow them thirty days to render payment in full. If we have not received payment after 45 days, you will be responsible for the entire balance. The quality of insurance policies can vary greatly, therefore, we can estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.

Payment for dental service is expected and required at the time of service, unless other arrangements have been made.

LATE PATIENT POLICY

Patients who arrive more than fifteen (15) minutes late to their scheduled appointment time may be asked to reschedule as a courtesy to our other scheduled patients.

Patient's Signature_____ Date: _____

Parent/Guardian Name (if patient is a minor): _____

Ponder Family Dental
Tyler P. Myser, DDS

HIPPA Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full—we must comply with this request;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Elect to opt out of receiving further fundraising communications from the office/hospital upon written request
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Dr. Tyler P. Myser, in person or in writing, during normal office hours. He will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you, and
- Notify you if you are affected by a breach of unsecured PHI

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint
If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Tyler Myser at (940) 479-0040. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Tyler Myser. You may also file a complaint by mailing it or e-

HIPPA Notice of Privacy Practices for Protected Health Information (continued)

mailing it to the Secretary of Health and Human Services whose street address and e-mail address is Corporations Section P.O. Box 13697Austin, Texas 78711-3697 or email Corpinfo@sos.texas.gov.
• We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
• We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Worker's Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: May 20, 2018

I, _____, hereby acknowledge that I have received a copy of this practice's HIPPA Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

Patient's Signature_____ Date: _____

Parent/Guardian Name (if patient is a minor): _____ Relationship to Patient: _____

Ponder Family Dental
Tyler P. Myser, DDS

HIPAA RELEASE FORM

I, _____, authorize the release of information on
(PRINT PATIENT / GUARDIAN NAME)

_____, including the diagnosis, records,
(PRINT PATIENT NAME)

examination and treatment rendered to above patient, ledger and billing, and claims information.

This information may be released to:

( ) Spouse_____

( ) Child(Children)_____

( ) Other_____

( ) Information is not to be released to anyone. (Initial Here)_____

In further consideration for this, Ponder Family Dental agrees to the same stipulations.

This Release of Information will remain in effect until terminated by me in writing.

Messages and communication from our office

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) other_____

The best phone number to reach me at is:_____

Signed: _____ Date: _____/_____/_____

Witness:_____ Date: _____/_____/_____