WILLIAM R. CLYDE, D.D.S., M.A.G.D., F.A.D.I.

707 TURTLE CREEK DRIVE

TYLER, TX 75701 (903)597-3331

Full Name:_____Preferred Name:_____

HM.#_____WK#_____Cell#_____

Mailing Address:_____City:_____State:_____Zip:_____

Birth date:____/____/_____Social Security #:_____Employer:_____

Spouse's Name:_____ Spouse's Employer:_____

Spouse's Phone #_____ Name of Emergency Contact:_____

Contact's phone #_____

If under 18, parent's name:_____Parent's Address:_____

City:_____State:_____Zip:_____Phone #:_____

How did you hear about our office?_____

Referred by:_____

Due to a MEDICAL reason, is antibiotic premedication necessary before dental work? _____ If yes, please explain_____

Do you have DENTAL insurance?_____If yes, please give your card to the receptionist to copy. **Please note that we are an OUT-OF- NETWORK provider. We will file your insurance and accept payment from your company. However, what insurance does not pay, the guarantor of your account is responsible for paying the remaining balance. Please check with your insurance company for out-of-network benefits.

Please CIRCLE any health conditions applicable to you:

AIDS (HIV positive)	Heart Murmur	Ulcers	Stroke
Anemia	Currently Pregnant	Sulfa Allergy	Other:_____
Anesthetic Allergy	Dental Implants	Tuberculosis	_____
Arthritis	Diabetes	Hepatitis	Allergies to Medication? Please explain
Artificial Joints	Epilepsy	High Blood Pressure	_____
Joint Implants	Frequent Headaches	Latex Allergy	_____
Asthma	Glaucoma	Penicillin Allergy	_____
Cancer	Heart Disease	Sinus Problems	

Dental Insurance- Please present your dental insurance card for copying upon arrival.

NOTE: Dental insurance is NOT the same as medical insurance or Medicare/Medicaid. Please be sure you have "Dental" Insurance before beginning treatment.

Dental Insurance Company's Name:_____

Insurance Company's Phone #:_____

Claim Filing Address:_____ City:_____State:_____Zip:_____

Group Name:_____Group #:_____Name of Subscriber:_____

Subscriber's Date of Birth:_____Subscriber's Social Security #:_____

Your Relationship to Subscriber:_____

NOTICE TO ALL PATIENTS- PLEASE SIGN AND DATE:

Regardless of insurance, you are responsible for the payment of your account. Our office will file dental insurance as a courtesy to you. We reserve the right to collect any unpaid balance. After 90 days, accounts with outstanding balances may accrue up to 18% annually.

I agree and understand the above financial terms. If I have dental insurance, I agree to my benefits being paid directly to Dr. William R. Clyde's office for services rendered. I also have received a copy of this office's Notice of Privacy Practices.

Patient Signature:_____Date:_____

Parent/Guardian's Signature (if under 18)_____Date:_____

Relationship to patient:_____

RELEASE CONSENT & AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient name_____Date of Birth: _____/_____/_____

Address:_____

City:_____State:_____ZIP:_____

Telephone Number:_____ E-mail address:_____

PATIENT AUTHORIZATION

I, _____, herby authorize the release, use of disclosure of my health information as follows. This authorization pertains to the following type of medical information about me:

_____

_____

_____

I hereby authorize_____ to release the above-described information to

_____

_____.

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I may revoke this authorization at any time by providing written notification to:

_____

_____

_____

The revocation will be effective on the date it has been received and processed by the above-named recipient. I understand that the revocation does not apply to actions taken in reliance upon this authorization prior to the effective date of revocation. I also understand that I do not have to sign this authorization in order to receive treatment, payment, or to enroll or be eligible for benefits.

PATIENT OR PERSONAL REPRESENTATIVE

Signature:_____ Date_____/_____/_____

Name (please print):_____

Relationship to patient:_____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information
- My privacy rights with regard to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitles to receive a copy of any revised *Notice of Privacy Practices* upon requests.

I also understand that if I have any questions or complaints, I may contact:

_____
_____
_____
_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

PATIENT OR PERSONAL REPRESENTATIVE

Signature:_____Date:_____/_____/_____

Name (Please Print):_____

Relationship to Patient:_____

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

_____Patient refused to sign (date of refusal) _____/_____/_____

_____Communications barriers prohibited obtaining an acknowledgment.

_____An emergency situation prevented us from obtaining an acknowledgment.

_____Other_____

Attempt was made by:_____ Date: ___/___/___