Austin
DENTAL CARE

SMILE SURVEY

1. What would you like to improve about your smile? (check all that apply)

   ____ Whiter, brighter teeth
   ____ Close gaps between teeth
   ____ Repair chipped or broken teeth
   ____ Replace missing teeth
   ____ Address crowded/overlapping teeth
   ____ Replace prior restorations that do not look natural
   ____ Improve my oral health routine

2. Do you experience tooth pain or sensitivity?
   If yes, please explain:

3. Is there anything else you would like us to know about your smile?
   If yes, please explain:

4. Reason for visit: Approximate date of last dental visit:

5. What is your *primary* concern that you would like us to address first?

6. Have you ever had any serious problem associated with previous dental treatment?
   If so, please explain:

7. What, if anything, has happened in previous dental experiences that kept you from returning?

8. Do you ever feel (or have you been told) that you don't have fresh breath?

We appreciate you choosing our practice for all your dentistry needs. Please let us know if there is anything we can do to make your visits with us more comfortable.

Dr. Glen M. Wainwright, DDS

Glen Wainwright, DDS
300 Beardsley Lane Bldg A, Suite 101, Austin, TX 78746
512-330-0255 / HYPERLINK "http://www.austindentalcare.com" www.austindentalcare.com

Privacy Notice

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of the Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information
You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make.

Treatment: We will use and disclose your protected health information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment: Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

Business Associates: We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Uses and disclosures of Protected Health Information based upon your written authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing except to the extent that our practice has already taken an action as provided for in the authorization.

Other permitted and required uses and disclosures that may be made with your consent, authorization or opportunity to object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the projected health information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the projected health information that is relevant to your health care will be disclosed.

Signature Date

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Financial Policy

In order to provide you with the highest quality service, we present fees and insurance benefit estimates, and payment options. Our goal is to eliminate confusion, simplify insurance claims, and provide more thorough coverage for our patients. Payment options include:

Cash or Check
Major Credit Cards *Visa, MasterCard, Discover & American Express*
Care Credit *Up to 12 month Interest Free (by approval only)*

For patients with dental insurance, our professional services are rendered to you, not to your insurance company. You are directly responsible to us for payment for treatment. As a courtesy, we accept assignment of benefit payments from most insurance companies. This will reduce your immediate out-of-pocket cost. We will do our utmost to help you maximize benefits to which you are entitled. Insurance estimates we give are based on limited information obtained regarding your insurance plan. We allow 45 days for your insurance company to make payment. After this time, all inquiries or follow-ups on insurance payments become your responsibility.

In fairness to all our patients, we ask that you ***notify our office at least 48 business hours in advance if you cannot keep your scheduled appointment****. For any appointments missed or cancelled/changed within 48 business hours of your scheduled appointment, we reserve the right to assess a minimum of $75.00 fee per occurrence. For excessive violations, we also reserve the right to require payment of full treatment fee (non-refundable) in advance to reserve an appointment OR discontinuation of our care for you.*

Acknowledgement: *I have read and agree to comply with the above policies, and I understand that if my account reaches collection status, and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Dr. Wainwright must take additional steps to collect my account, I will pay ALL costs of collection, including court costs and attorney's fees incurred by Dr. Wainwright.*

Signature _____

Date

We appreciate you taking time to read and acknowledge our financial policy. We are committed to providing you the highest quality care and service. If you have any questions, please contact our financial coordinator who will be happy to review the agreement with you at any time.

Appointment Commitment

Welcome to our care! For your convenience, here is some important information about our commitment to you!

At Austin Dental Care, we commit to treating our patients in a timely fashion. We work hard to respect your schedule and care for you at your appointed time. We ask that when you reserve an appointment with us, please arrive on time, and we will do everything possible to care for you on time!

If you ever find it a challenge to keep your appointments, we ask for ***48 business hours advance notice*** *when cancelling or changing appointments. If advance notice is not given, we reserve the right to monitor these occurrences, and assess a cancellation fee. Excessive appointment changes or cancellations may result in our inability to further care for you.*

We appreciate your commitment to your dental health, and look forward to caring for you!

Signature (Patient/Guardian) _____

Date _____