Mary Bennett Houston DDS, PA

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices. Copy available upon request.

____ ____________________________

Patient or representative signature Date

Relationship to Patient self ________ parent ________ spouse ________ other ______________________

AUTHORIZATION

Below are the people that have access to my medical/dental records and information to schedule appointments. We will not discuss your information with anyone without specific signed authorization. I hereby authorize the following person(s) to communicate with Dr. Mary Bennett Houston and Staff regarding all pertinent aspects of my medical/dental care.

____________________________________ ____________________________________

print name relationship

____________________________________ ____________________________________

print name relationship

DENTAL HISTORY

Reason for today's visit ____ Date of last visit ______________________

Former Dentist ____ Date of last dental x-ray __________________

Address ____ Telephone ____________________

Check if you have had problems with any of the following:

- ___Bad breath
- ___Bleeding gums
- ___Clicking or popping jaw
- ___Food collection between teeth
- ___Accident or trauma to jaw or teeth
- ___ Grinding teeth
- ___ Loose teeth or broken fillings
- ___ Periodontal treatment
- ___ Sensitivity to cold
- ___ Sensitivity to heat
- ___ Sensitivity to sweets
- ___ Sensitivity when biting
- ___Sores or growths in your mouth

How often do you floss? ________________________________ How often do you brush? ________________________

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it my responsibility to inform my dentist if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ____________________________________ and assign

Name of Insurance Company(ies)

directly to Dr. Mary Bennett Houston all insurance benefits, if any, otherwise payable to me for services rendered. I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services,

____ ________________________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ________________________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient