Jack A. Wilson, DDS Inc.
Eric M. Wilson, DDS
2200 West I-20 Ste. 200 Arlington, TX 76017
Phone: 817-467-0727 fax: 817-465-2372

Dear Patient,

We are very happy to welcome you to our dental practice and want you to know that we appreciate the chance to take care of you and your family! Our office is focused on providing you with high quality, gentle dental care.

During your first visit, the doctor will examine your teeth, perform an oral cancer exam, review necessary x-rays, and make an assessment of your oral condition. Staff members will assist the doctor in completing your oral health evaluation and you will be meeting several members of our dental team.

If it is discovered that you need any dental treatment, a treatment plan will be prepared for you prior to beginning any procedures. You will have the chance to review recommended treatment and ask questions.

Please complete the Patient Information form and sign the HIPAA privacy notice and bring pages 4 & 5 with you to your first appointment. If you have dental insurance, please bring your insurance card and any applicable information with you as well. We ask that you arrive 10 minutes early for your first appointment to allow us time to verify your insurance information. We are happy to help you obtain your insurance benefits and will assist you in filing your claims.

Thank you for choosing our office! We are looking forward to meeting you!

Sincerely,

Dr. Jack Wilson, DDS
Dr. Eric Wilson, DDS
and Staff

HIPAA Privacy Notice

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 22, 2009, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: s explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer 2200 W I-20 #200 Arlington, TX 76017.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer 2200 W I-20 #200 Arlington, TX 76017. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 2200 W I-20 #200 Arlington, TX 76017.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 2200 W I-20 #200 Arlington, TX 76017. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
2200 W I-20 #200 Arlington, TX 76017
Telephone: (817) 467-0727

Patient Information

Name_____ Today's Date _____

Address _____ City, State, Zip _____

Cell Phone # _____Email _____

Birth date _____ Social Security # _____ Marital Status _____

Please tell us how you found us     Referring person's Name_____

Name of person responsible for this account?

Name_____ phone # _____

Relationship to patient Self Spouse Parent Step-Parent

Address _____City, State, Zip_____

Employer _____ Position _____

Address_____

City, State, Zip _____

Work Phone # _____ Ext. _____

Student (No/Full/Part) _____ School _____ Grade _____

Medical History

Are you allergic to the following? (Please circle) Mint Clove Latex

Circle Y (yes) N (no) if you had or currently have any of the following:

Y N Heart Murmur	Y N High Blood Pressure	Y N Asthma/Emphysema
Y N Heart Condition	Y N Epilepsy/Seizures	Y N Anemia
Y N Rheumatic Fever	Y N Hepatitis	Y N Tuberculosis
Y N AIDS	Y N Cancer (Type/date) _____	
Y N Diabetes	Y N Pregnant (Due date/Doctor) _____	

Other medical conditions we should be aware of_____

_____

Family doctor _____ Phone #_____

Required Medications _____

Drug reactions/allergies _____

Surgeries (please include date) _____

Is pre-medication required? YES NO

Pharmacy _____ Address _____ Number _____

DENTAL Insurance Information

Insurance Company Name _____ Group #_____

I.D.# _____ Date Of Birth _____

Address _____ Phone # _____

City, State, Zip _____

Cardholder/Employee _____

Address _____ Phone # _____

City, State, Zip _____

SS # _____ Date of Birth _____

Relationship to Patient Self Spouse Parent Step-Parent

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*Notice of **HIPAA Privacy Notice** (PAGE 2 &3)*

Jack A. Wilson, DDS, Inc.

A copy of the HIPAA Privacy Notice has been given to me and by signing below; I acknowledge receipt of said notice and have carefully read and understood my rights pertaining to my medical/dental information and how it may be disclosed.

Patient Signature _____ Date _____

Patient Name _____ Date of Birth _____

Family Information

Spouse's Name _____

Employer _____ Position _____

Work # _____ Cell # _____

Social Security # _____ Date of Birth _____

Children:

Name_____ Birth date _____
Name_____ Birth date _____
Name_____ Birth date _____
Name_____ Birth date _____
Name_____ Birth date _____

I authorize Jack A. Wilson, DDS and/or Eric M. Wilson, DDS, to perform and diagnostic procedure(s)/treatment(s) as may be necessary for proper dental care. I authorize and release any information concerning my or my child's health care, advice and treatment to any other medical professional. I have read all the information on both sides of this sheet and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

I understand there is a $25.00 fee for a missed or cancelled appointment with less than 24 hours notice to this office. I understand if I am more than 10 minutes past my appointment time I will be asked to reschedule.

Patient Signature _____ Date _____
