Randall Lamb DDS

8810 Tarter Avenue Amarillo, Texas 79121
(806)351-0600

Patient Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Name_____ **Today's Date**_____

Medical History Information

Physician: _____ _____ Office Number: _____ Date of last Exam_____

Who do we notify in the case of an emergency?

_____

1. Are you under medical treatment now? No Yes
   If yes, please explain_____
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? No Yes
   If yes, please explain: _____
3. Are you taking any medications including non-prescription medicine? No Yes
   If yes, please list _____
4. Have you ever taken Phen-Fen/Redux? Yes No
5. Do you use tobacco? No____ Yes_____ Smoke or Dip
6. Are you allergic to or have you had any reactions to the following:

Local Anesthetic	Penicillin or any other Antibiotics	Latex Rubber
Sulfa Drugs	Barbiturates	Aspirin
Sedatives	Iodine	Metals
Other_____		

7. Women Only:
   (a). Are you pregnant or think you may be pregnant? Yes No
   (b). Are you nursing? Yes No
   (c). Are you taking oral contraceptives? Yes No

Do you have or have you had any of the following? Please circle those that apply.

Allergies	Fainting/Seizures	Liver Disease
Anemia	Frequently Tired	Mitral Valve Prolapse
Angina	Glaucoma	Osteoporosis
Arthritis	Hay Fever	Radiation Therapy
Asthma	Heart Condition	Respiratory Problems
AIDS/HIV	Heart Attack	Rheumatic Fever
Cancer	Heart Murmur	Sexually Transmitted Disease
Cardiac Pacemaker	Hepatitis A, B, or C	Stomach Trouble
Chest Pains	High Blood Pressure	Stroke
Diabetes	Jaundice	Swollen Ankles
Easily Winded	Joint Replacement/ Implant	Thyroid Problem
Emphysema	Kidney Disease	Tuberculosis
Epilepsy/Convulsions	Leukemia	Weight Loss

Signature_____

Dental History Information

Date of Last Dental Visit:_____ Reason for That Visit: _____

1. Do your gums bleed while brushing or flossing? Y / N
2. Are your teeth sensitive to hot or cold liquids/foods? Y / N
3. Are your teeth sensitive to sweet or sour liquids/foods? Y / N
4. Do you feel pain to any of your teeth? Y / N
5. Do you feel pain to any sores or lumps in or near your mouth? Y / N
6. Have you had any head, neck or jaw injuries? Y / N
7. Have you ever experienced any of the following problems In your jaw:

   Clicking – Pain – Difficulty in opening, closing, chewing
8. Do you have frequent headaches? Y / N
9. Do you clench or grind your teeth? Y / N
10. Do you bite your lips or cheeks frequently? Y / N
11. Have you ever had any difficult extractions? Y / N
12. Have you had any orthodontic treatment? Y / N
13. Do you wear dentures or partials? Y / N
14. Have you ever received oral hygiene instructions? Y / N
15. Do you like your smile? Y / N

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice: _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Randall Lamb, D.D.S.
8810 Tarter Ave
Amarillo, TX 79121
806-351-0600

Office Financial Policy

I understand that payment is expected at the time of service. We will accept cash, check, or credit card (Visa, Mastercard, Discover and Care Credit).

I authorize and request my insurance company to pay directly to Dr. Randall Lamb Benefits otherwise payable to me. As a service to you, we will submit your dental insurance claims.

I understand that my dental insurance carrier may pay less that the actual bill for my services and I agree to be responsible for payment of åll services rendered on my behalf or my dependents.

I understand that it is absolutely impossible for Dr Lamb's office manager to determine the exact amount that will be paid by insurance and, as such, the exact amount owed by me the responsible party.

I agree to pay what is asked of me at the time of service considering deductibles, co-pays, and procedure percentages as faithfully determined by Dr Lamb's office manager. If we underestimate your portion at the time of service, you will be billed for the difference. If we over estimate your portion at the time of service, the difference will be credited to your account or refunded to you by check.

I understand that payment plans are not financed through the office, except for orthodontic cases. As a service to you we have arranged for financing through Care Credit upon credit application approval.

A cancellation fee may be charged for appointments that are canceled less than 24 hours prior to the appointment. A 24 hour notice allows our office to fill that time slot. We do understand that there are times that a 24 hour notice is not possible.

_____ Date:_____

Signature of patient, parent, or guardian

For your records:

Randall D. Lamb D.D.S

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state 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 April 14 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to 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 make the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request

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 us using the information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We 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 a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

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. licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization While it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose your health information to notify, or assist in the notifications of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we wait provide you with an opportunity to object to such uses or disclosures. in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional Judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience With common practice to make reasonable inferences on your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe than you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health Information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information

required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You may have the right to look at or get copies of your health information, with limited exceptions- You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost—based fee for expenses such as copies and charge you $0.15 for each page, $25 per hour for staff time to locate the copy of your health information and postage if you want the copies mailed to you. lf you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosing Accounting: 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, 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 for a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), 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, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, 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 will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

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 US. Department of Health and Human Services.

Contact Officer: **Randall D. Lamb D.D.S**

Telephone: **1-806-351-0600**

E-mail: **kim@lambdental.com**

Address: **8810 Tarter Amarillo, TX 79119**