MONTGOMERY COUNTY PERIODONTAL ASSOCIATES
MILES A. MASON, PLLC
MILES A. MASON, DDS, MSd
Diplomate- American Board of Periodontology

601 River Pointe #110
Conroe, Texas 77304
Fax 936-756-1691
936-756-1669

PRACTICE LIMITED TO REGENERATIVE PERIODONTAL MEDICINE & ORAL IMPLANTOLOGY

1001 Medical Plaza Drive #110
The Woodlands, Texas 77380
Fax 281-367-5622
281-363-2009

WELCOME

We are pleased to welcome you as a new patient. In order to serve your needs effectively, we feel you should become acquainted with our goal and services.

We appreciate your concern about periodontal infection, the most prevalent systemic bacterial disease in the world. Before any treatment can begin, a diagnosis and evaluation are made by periodontal probing to detect bone loss, from x-ray interpretation, and through other diagnostic procedures. After the evaluation, you will be informed of the extent of your periodontal problems, advised of a reasonable and safe treatment plan to correct or modify these problems, and provided an estimate of the time and cost.

The initial comprehensive evaluation may require more than one appointment depending on the severity of your disease, and no definitive treatment will be initiated until the full evaluation is complete. The fee for the initial examination and consultation is $139.00 payable the day of your visit. A full-mouth radiographic series of periodontal density is required of all patients. If such x-rays are not available from your referring doctor, we will take a series and the fee for this service will be $115.00.

Our commitment is to provide the highest quality periodontal treatment in a comforting and caring manner. We are dedicated to correcting, improving, and maintaining your overall health while making every effort to save your bone support and natural teeth.

All appointments are Monday- Friday, and we attempt to schedule appointments at a time that is mutually convenient as we realize the value of your time. Promptness on your part is greatly appreciated.

Please feel free to ask questions about your personal evaluation and treatment program. Thank you for coming to see us as we are here to help you.

Sincerely,

Miles A. Mason, DDS, MSd

MONTGOMERY COUNTY PERIODONTAL ASSOCIATES
MILES A. MASON, PLLC
Miles A. Mason, DDS MSd
Diplomate American Board of Periodontology

601 River Pointe Dr. #110
Conroe, Texas 77304
FAX 936-756-1691
936-756-1669

PRACTICE LIMITED TO REGENERATIVE PERIODONTAL MEDICINE & ORAL IMPLANTOLOGY

1001 Medical Plaza Drive #110
The Woodlands, Texas 77380
FAX 281-367-5622
281-363-2009

PATIENT INFORMATION

PATIENT NAME _____ SSN _____ DL _____

ADDRESS _____ ACCOUNT # _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ AGE _____ DOB _____

EMPLOYER'S NAME/ADDRESS _____

_____

OCCUPATION _____ BUSINESS PHONE _____

MARITAL STATUS _____ SPOUSE NAME _____ SPOUSE SSN _____

EMERGENCY CONTACT _____ PHONE _____

INDIVIDUAL RESPONSIBLE FOR ACCOUNT _____ PHONE _____

INSURED'S NAME _____ INSURED'S DOB _____ INSURED'S SSN _____

INSURED'S ADDRESS (if different) _____ PHONE (if different) _____

INSURED'S EMPLOYER _____ PHONE _____

EMPLOYER ADDRESS _____

DENTAL INSURANCE COMPANY _____ POLICY/GROUP # _____

COMPANY ADDRESS _____ PHONE _____

PATIENT REFERRED BY _____

PATIENT'S DENTIST _____ PHONE _____

MEDICAL HISTORY

PERSONAL PHYSICIAN _____ PHONE _____

DO YOU NOW HAVE OR HAVE YOU **EVER** HAD (check Items that apply)

_____ Heart Trouble/Attack/Surgery	_____ Hepatitis or Jaundice	_____ Cancer
_____ Stroke/Angina	_____ Liver Disease	_____ Chemotherapy
_____ High Blood Pressure	_____ Sexually Transmitted Disease	_____ Radiation Treatment
_____ Heart Murmur	_____ Tuberculosis	_____ Recent Weight Change
_____ Artificial Heart Valve(s)	_____ Ulcers	_____ Chest Pains/Short Breath
_____ Mitral Valve Prolapse	_____ Kidney Disease	_____ Asthma/Emphysema
_____ Heart Pacemaker	_____ Glaucoma	_____ Bronchitis
_____ Rheumatic Fever	_____ Frequent/Severe Headaches	_____ Hay Fever/Sinusitis
_____ Prolonged Excessive Bleeding	_____ Psychiatric Treatment	_____ Hives or Skin Rash
_____ Abnormal Clotting	_____ AIDS/HIV Positive	_____ Arthritis
_____ Anemia/Blood Disease	_____ Epilepsy or Convulsions	_____ High Cholesterol
_____ Diabetes/Hypoglycemia	_____ Thyroid Gland Problems	_____ Osteoporosis

American Society of Anesthesia (ASA) status:
I_____ II_____ III_____ IV_____ V_____

Other Illness or Disease _____ Do you take **ASPIRIN** or **BLOOD THINNERS?** _____

Allergic Reaction to: Sulfa Drugs _____ Penicillin _____ Codeine/Sedatives _____ Other Allergies _____

When was your last blood test? _____ Have you ever had a transmissable disease? _____

Do you wear contact lenses? _____ Have you been out of the USA in the last 3 months? _____

List hospitalizations or surgery in the last 3 years _____

WOMEN Are you pregnant? _____ Are you taking birth control pills or hormones? _____

Do you get yeast infections after taking antibiotics? _____

MEN Have you been treated for BPH (benign prostatic hypertrophy)? _____

Please List **ALL MEDICATIONS and VITAMIN SUPPLEMENTS** you are now taking or have taken within the last 3 months:

DRUG NAME	Mg/Unit EACH DOSE	EACH DAY TAKEN HOW OFTEN	DURATION TAKEN HOW LONG	REASON FOR TAKING

DENTAL HISTORY

YES	NO	
_____	_____	Are your teeth sensitive to hot or cold?
_____	_____	Do you awaken with sore jaws?
_____	_____	Do you clench or grind your teeth?
_____	_____	Can you chew evenly on both sides?
_____	_____	Have you noticed your bite changing?
_____	_____	Have you noticed spaces developing between your teeth?
_____	_____	Have you ever had a gum abscess?
_____	_____	Have you had previous gum trouble?
_____	_____	Are you satisfied with the way your teeth or gums look?
_____	_____	Do you want to save your teeth, if possible?
_____	_____	Have you ever had orthodontic treatment (braces)?
_____	_____	Do you notice popping, clicking or soreness in the joints just in front of your ears (TMJ)?
_____	_____	Have you ever had complications during or after a dental procedure?
_____	_____	Do you feel your present oral hygiene is effective in cleaning your mouth?'
_____		How many times a year do you have the bacteria removed from your mouth (teeth cleaned)?
_____		Date your teeth were last cleaned.
_____		Date of last full-mouth dental x-rays.
		What type of toothbrush do you use? _____ soft _____ medium _____ hard
		What concerns you most about your mouth? _____
_____	_____	Do you smoke or use products containing nicotine?
_____	_____	Do you drink 6-8 glasses of water daily?

Circle the foods you generally **avoid** eggs milk cheese yogurt bread/pasta
seafood chicken red meat fresh vegetables fresh fruit

How much of each do you consume daily? _____cigarettes _____ other tobacco _____ water

_____ coffee _____ tea _____ soft drinks _____ alcoholic drinks

Do you have any disease, condition or problem not covered above that you think we should know about or that you believe would affect healing and periodontal treatment? If so, please state: _____

_____ _____
Signature Date

_____ _____
Witness Date

MONTGOMERY COUNTY PERIODONTAL ASSOCIATES
MILES A. MASON, PLLC

Miles A. Mason, DDS, MSd

Notice of Privacy Practices

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 07/09/2015, 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 made 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 this 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 for 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 health information to notify, or assist in the notification 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, prior to use or disclosure of your health information, we will 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 that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of 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 that 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 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 staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.__ for each page, $__per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If 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).

Disclosure 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 a reasonable, cost based fee for responding to these additional requests.

Restriction: 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.

Contact Officer: Miles A. Mason, DDS, MSd
Telephone: 281-363-2009 Fax: 281-367-5622
E-mail: info@montgomerycountyperio.com
Address: 1001 Medical Plaza Dr, Ste 110, The Woodlands, TX 77380

MONTGOMERY COUNTY PERIODONTAL ASSOCIATES
MILES A. MASON, PLLC
Miles A. Mason, DDS, MSd

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, (parent of, if a minor) have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name Of Patient

_____
Signature

_____
Date

I, _____, will allow the above named entity to disclose my health information to: (List Names and relationship below)

Name	relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify)

_____

_____

_____

MILES A. MASON, DDS, MSd
Montgomery County Periodontal Associates
Diplomate American Board of Periodontology

1001 Medical Plaza Dr, Ste 110
The Woodlands, TX 77380
281-363-2009

601 River Pointe Dr, Ste 110
Conroe, TX 77304
936-756-1669

How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Today's Date: _____

Check or complete <u>all that apply</u> (please print clearly):

____ Contact me by U.S. Mail at the following address: _____
____ Contact me by email at the following address: _____

For Phone and Text Communications:

This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number: _____

_____ **I consent to the following:** Montgomery County Periodontal Associates or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, Dr. Mason calling you after surgery, payment, my account or insurance, using telephone equipment that may be capable of automatic dialing. Montgomery County Periodontal Associates may:

_____ Call me
_____ Text me
_____ Call me and text me

Signature: _____ Date: _____

Please call Montgomery County Periodontal Associates right away if you get a new telephone number

---

For Office Use Only:
_____ Consent revoked. Date/Initials: _____/_____
_____ Possible reassigned number. Date/Initials: _____/_____
_____ Confirmed accurate. Date/Initials: _____/_____ Date/Initials: _____/_____
Date/Initials: _____/_____ Date/Initials: _____/_____
Date/Initials: _____/_____ Date/Initials: _____/_____

MONTGOMERY COUNTY PERIODONTAL ASSOCIATES
MILES A. MASON, PLLC
Miles A. Mason, DDS, MSd
Diplomate American Board of Periodontology

601 River Pointe Dr. #110
Conroe, Texas 77304
FAX 936-756-1691
936-756-1669

PRACTICE LIMITED TO REGENERATIVE PERIODONTAL MEDICINE & ORAL IMPLANTOLOGY

1001 Medical Plaza Drive #110
The Woodlands, TX 77380
FAX 281-367-5622
281-363-2009

PERIODONTAL THERAPY CONSENT
For Oral Diagnosis and Periodontal Surgery

I, _____, have been informed that the purpose of periodontal therapy is to treat my periodontally diseased gum tissues, tooth roots, and supporting alveolar bone structures. This is my consent to periodontal surgical therapy, muco-gingival therapy to correct gum recession, curettage, or other oral surgery deemed necessary or advisable due to actual pathology including bone grafting or surgical extraction of hopeless teeth.

If sedative drugs have been prescribed for my safety and comfort during the procedure, I agree that I will arrange to be driven **to** and **from** the office and that I will not drive for the remainder of the day.

I also agree to the use of topical and local anesthetic, oral sedation, intravenous sedation (I.V.), or nitrous oxide analgesia (laughing gas) as safe and advisable as the doctor recommends. Possible risks of parenteral conscious sedation anesthesia, as with any type anesthesia, include cardiac arrest, brain injury, and death.

I am aware of the possible complications and post-operative risks of surgery, anesthesia, and therapeutic drug use. Complications could include, but are not limited to: swelling, discomfort or infection in the mouth or I.V. insertion site; restricted mouth opening; paresthesia (numbness) of the jaw or gum nerves; esthetic changes such as increased tooth length exposing crown margins and gum recession (shrinkage); temporary interference with phonetics (speech sounds); and sensitivity to hot or cold for days, weeks, or occasionally several months.

I also realize that having this therapy does not preclude the possibility that one or more teeth may eventually be lost. I further understand that if no treatment is rendered, my present periodontal condition will probably worsen over time resulting in permanent tooth loss.

No guarantee or assurance has been given to me that the proposed treatment will be successful to my complete satisfaction. Due to individual pathology and existing bone loss, there exists a small risk of failure, the possibility of relapse, the need for selective re-treatment, or the worsening of my present condition despite the best periodontal care.

I understand that long-term success depends on my long-term continued performance of excellent oral hygiene and daily plaque removal, flossing after each meal, and my availability for regular periodontal maintenance visits.

I further give my consent to the taking of photographs of my mouth during surgery and/or post-operative photographs for educational purposes in dental schools, scientific publications, or for lectures to colleagues or for the public interest.

I also realize that I am fully responsible for complete and prompt payment of my account when due regardless of the amount insurance may cover or should there be a delay in payment by my insurer.

_____ _____
PATIENT OR Legal Guardian Date

_____ _____
Witness Date

PROFESSIONAL FEES

All patients are concerned about the cost of health care, and we would like you to know that we strive to hold down our professional fees and can continue to do so with your help.

FINANCIAL ARRANGEMENTS Fees for examinations and consultations, x-rays, maintenance visits, and emergency services are payable at the time professional services are rendered.

For periodontal treatment programs, fees are estimated based on the information available concerning actual bone damage at that time. Final fees can be determined only following corrective therapy to assess the actual bone destruction. Occasionally, additional charges may be incurred during periodontal therapy or surgery; such charges would be added to the balance due.

Please make arrangements for payment by selecting from among the following options:

- Full payment at time of service - 5% bookkeeping discount for payment before treatment is rendered.
- MasterCard, Visa, or Discover.
- IF you have dental insurance – you pay 50% of the proposed treatment. If we are overpaid you will receive a refund check, if you have a balance due we will bill you.
- Outside Financing – For those who would prefer an extended payment plan. We offer Care Credit @ 800-365-8295 or www.carecredit.com, or Lending Club @ 800-630-1663 or lendingclub.com/dental.
- Patients with non-traditional discount plans (i.e. Aetna DMO, CareIngton, Dorsey, & Comp Benefits, American Dental Care, etc.) must pay their portion in full in order to qualify for the applicable discount associated with the individual plan.

All accounts must be cleared in full within 60 days. Past due accounts will be reported to the credit bureau and turned over to a collection agency.

APPOINTMENT CANCELLATIONS Since our treatment appointments are lengthy, cancellations can be problematic. We understand emergencies do arise and there is no penalty for 48-hour notice at such a time. However, unless 48-hour notice of an unforeseen circumstance has been given, rescheduling for a treatment will not be made unless there has been full payment for the procedure.

Again, thank you for your trust and confidence. Please feel free to ask any questions of me or the staff. We are here to help you.

I have read and understand the above and wish to accept professional treatment.

_____ _____

Patient Signature Date Witness Signature Date