# TEJAS HEALTH CARE

1-844-TEJAS-4-U
WWW.TEJASHEALTHCARE.ORG

890 E. Travis Street
La Grange, TX 78945

275 Ellinger Road
La Grange, TX 78945

185 Decker Drive
Giddings, TX 78942

## DENTAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Please answer all of the following questions by circling YES or NO. Your responses will be strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concern to a member of our team.

| Do you have or have you ever had any of the following? | | | FOR OFFICE USE ONLY: |
|---|---|---|---|
| Angina (Chest Pain) | Yes | No | |
| Arthritis | Yes | No | |
| Artificial Joints: Hips/Knee/Ankle/Shoulder/Other: | Yes | No | |
| Asthma | Yes | No | |
| Bleeding Problem: Anemia/Other Blood Disease: | Yes | No | |
| Cancer | Yes | No | |
| Congenital Heart Defect | Yes | No | |
| Congestive Heart Failure | Yes | No | |
| Diabetes | Yes | No | |
| Fainting/Seizures/ Nervous System Disease (Epilepsy/Convulsions) | Yes | No | |
| Glaucoma | Yes | No | |
| Hearing Impairment | Yes | No | |
| Heart Attack or Heart Disease | Yes | No | |
| Heart Murmur or Mitral Valve Prolapse | Yes | No | |
| Heart Valve Replacement | Yes | No | |
| Hepatitis A, B, C, or Other: | Yes | No | |
| High Blood Pressure | Yes | No | |
| Immunosuppressive Condition:<br>Steroid Therapy Radiation Therapy Chemotherapy SLE (Lupus) HIV<br>Organ Transplant Spleen Removal Other: | Yes | No | |
| Irregular Heart Beat | Yes | No | |
| Kidney Disease | Yes | No | |
| Mental Health Condition – Specify: | Yes | No | |
| Other Artificial Implants or Devices | Yes | No | |
| Other Liver Disease | Yes | No | |
| Other Lung Disease | Yes | No | |
| Other Muscle or Joint Disease | Yes | No | |
| Pacemaker or Defibrillator | Yes | No | |
| Previous Bacterial Endocarditis | Yes | No | |
| Rheumatic Fever/Rheumatic Heart Disease | Yes | No | |
| Sexually Transmitted Disease/Infection | Yes | No | |

| | | | |
|---|---|---|---|
| Stomach or Intestinal Disease (Ulcer/GERD) | Yes | No | **FOR OFFICE USE ONLY** |
| Stroke | Yes | No | |
| Thyroid Disease | Yes | No | |
| Tuberculosis | Yes | No | |
| Visual Impairment | Yes | No | |
| Do you have any diseases, conditions/problems that were not listed? If yes, please list: | Yes | No | |
| Please list any hospitalizations and surgeries: | | | |
| Do you have any allergic reactions to medications or latex? If yes, please list: | Yes | No | |
| Have you ever undergone current or past osteoporosis therapy? Medications such as: Fosamax Actonel Boniva | Yes | No | |
| Have you ever undergone current or past bisphosphonate therapy? Had intravenous therapy with medications such as: Aredia Zometa | Yes | No | |
| Are you currently taking any blood thinners such as: Oral Anticoagulants: Pradaxa Warfarin Coumadin Oral Antiplatelet : Aspirin Plavix | Yes | No | |
| Are you or could you be pregnant? If yes, how far along are you? | Yes | No | |
| Are you breastfeeding? | Yes | No | |
| Are you taking birth control? | Yes | No | |
| Are you or have you ever been addicted to a chemical substance such as: Alcohol / Prescription Drugs / Heroin / Meth / Cocaine Other: | Yes | No | |
| Do you smoke or use Tobacco products? If yes, how many do you use a day: | Yes | No | |
| Do you have a parent, sibling, or child that has the following? (Please circle all that apply): Diabetes High Blood Pressure Heart Disease Bleeding Tendency Cancer | Yes | No | |
| Are you currently taking any prescription medications, over the counter items or herbal supplements? If yes, please list: | Yes | No | |

| **Name of Medication:** | **Dosage:** | **Reason for taking:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **DENTAL HISTORY CONTINUED** | | | **FOR OFFICE USE ONLY:** |
|---|---|---|---|
| Reason for Today's Visit: | | | |
| Do you have regular dental checkups? If yes, when was your last dental exam: | Yes | No | |
| Have you had any trouble with previous dental treatment? If yes, please explain: | Yes | No | |
| Have you noticed any lumps or sores in your mouth? | Yes | No | |
| Do your gums bleed when you brush your teeth? | Yes | No | |
| Do you clench or grind your teeth? | Yes | No | |

| | | | |
|---|---|---|---|
| Do you have any pain in the mouth, face, eyes, neck or throat area? | Yes | No | |
| Have you injured your face, jaw, or teeth? | Yes | No | |
| Are you unhappy with the look of your teeth and/or smile? | Yes | No | |
| Circle any of the following dental procedures that you have had done:<br>Orthodontics (Braces) Dentures Root Canal Treatment Implants Oral Surgery<br>Periodontal (Gum) Treatment Fillings TMJ Treatment Bridges Veneers Bleaching | | | |
| How many times per day do you brush your teeth? | | | |
| How many times per day do you floss? | | | |
| **PLEASE ANSWER THE FOLLOWING FOR ALL CHILDREN (0-18):** | | | **FOR OFFICE USE ONLY:** |
| Does child suck their thumb or fingers? | Yes | No | |
| Does child suck or bite their lip? | Yes | No | |
| Does child use fluoride toothpaste? | Yes | No | |
| Does a parent or adult help child with brushing? | Yes | No | |
| Does child eat sugary foods and/or snacks? If yes, please circle:<br>With meals only 1-2 times between meals More than 2 times between meals | Yes | No | |
| Does child drink anything besides water or milk? If yes, please circle:<br>With meals only 1-2 times between meals More than 2 times between meals | Yes | No | |
| What kind of water does child drink? Please circle:<br>Bottled/ Jug Refill Filtered Tap Well Water Fluoride Nursery | | | |
| Is or was the child given a bottle or Sippy cup to suck on to fall asleep? | Yes | No | |
| Does anyone in the family have cavities? Please circle:<br>Mother Father Siblings | Yes | No | |

To the best of my knowledge all the preceding information is correct and complete. If I have any changes in my health status, or any changes in medication, I will inform the dental health provider on my next appointment. I am responsible for any errors or omissions of information. I consent to all examinations including exams, x-rays and other tests that may be necessary in the judgment of the provider or diagnostic purposes.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

# TEJAS HEALTH CARE

**1-844-TEJAS-4-U**

**WWW.TEJASHEALTHCARE.ORG**

890 E. Travis Street
La Grange, TX 78945

275 Ellinger Road
La Grange, TX 78945

185 Decker Drive
Giddings, TX 78942

## DENTAL CONSENT

Patient Name: _____ Date of Birth: _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at Tejas Dental Clinic. These procedures include, but are not limited to; examinations, oral prophylaxes (cleaning), fluoride treatments, sealants, restorations (amalgam or composite feelings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand nd that the use of local anesthetics carries a mall risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

I further acknowledge that I have been informed of the possible significant risks and complications involved during or after treatment to be rendered, including:

- Post-operative pain, swelling, bleeding, and bruising
- Infection and/or prolonged healing
- Temporary or prolonged numbness, altered sensation of the lip, chin, tongue, gums or teeth
- Entry (or displacement of teeth) into maxillary sinus, with possible sinus infection and/or oral sinus communication(perforation from mouth into sinus)
- Loss of vitality (nerve/blood vessels) or damage to adjacent teeth/fillings
- Possible inadvertent incision of tongue, cheek, or lips

I authorize and ask for interpretation of any additional procedures in which I will give consent being necessary or convenient for the oral health and wellness of myself or child and understand the professional judgment of the dentist at Tejas Health Care.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction.

_____ _____

Print Name of Patient Date

_____

Signature of Patient

_____ _____

Signature of Witness Date

**THIS SECTION NEEDS TO BE COMPLETED FOR CHILDREN UNDER THE AGE OF 18 BY A PARENT OR LEGAL GUARDIAN ONLY.**

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Legal Guardian Signature: _____ Date: _____

# TEJAS HEALTH CARE

**1-844-TEJAS-4-U**

**WWW.TEJASHEALTHCARE.ORG**

890 E. Travis Street
La Grange, TX 78945

275 Ellinger Road
La Grange, TX 78945

185 Decker Drive
Giddings, TX 78942

## NEW PATIENT REGISTRATION

| PATIENT INFORMATION: | | |
|---|---|---|
| PATIENT NAME (LAST, FIRST, MIDDLE): | DATE OF BIRTH: | TODAYS DATE: |
| | | |
| SOCIAL SECURITY NUMBER: | SEX AT BIRTH: | |
| - - | ___ Male ___ Female ___ Other | |
| MAILING ADDRESS: | PHYSICAL ADDRESS: (IF DIFFERENT THAN MAILING ADDRESS) | |
| | | |
| CITY – STATE – ZIP: | CITY – STATE – ZIP: | |
| CELL PHONE: | WORK PHONE: | |
| HOME PHONE: | EMAIL: | |
| PREFERRED METHOD OF COMMUNICATION: ___ Telephone ___ Email (Patient Portal) ___ US Mail | | |

| INSURANCE INFORMATION: (PLEASE FILL OUT COMPLETELY) | | | |
|---|---|---|---|
| PRIMARY INSURANCE: | ID NUMBER: | GROUP NUMBER: | POLICY HOLDER'S NAME: |
| | | | |
| SECONDARY INSURANCE: | ID NUMBER: | GROUP NUMBER: | POLICY HOLDER'S NAME: |
| | | | |

| | |
|---|---|
| PREFERRED LANGUAGE: | ___ English ___ Español ___ Other: |
| MARITAL STATUS: | ___ Single ___ Married ___ Widowed ___ Divorced |
| ETHNICITY: | ___ Hispanic or Latino ___ NOT Hispanic or Latino |
| RACE: | ___ White or Hispanic ___ Black or African American ___ Asian ___ American Indian or Alaska ___ Native Hawaiian ___ Other Pacific Islander |
| ARE YOU LIVING: | ___ Doubled Up (Living with others) ___ In a homeless Shelter ___ On the street ___ Transitional Housing ___ NOT Homeless |
| VETERAN STATUS: | ___ Active Duty ___ Discharged (Veteran) ___ National Guard ___ Reserve ___ None |
| FARMER STATUS: | ___ Migratory Farm Worker ___ Seasonal Farm Worker ___ Not a Farm Worker |

*Please provide the information requested to help assist Tejas Health Care in receiving funding which allows us to provide health care to our communities most vulnerable.*

What is your monthly household income: _____ How many people are in your household? (Including yourself) _____

***If you choose not to provide this information, please initial here:*** _____

| PARENT/GUARDIAN INFORMATION – ONLY FILL OUT IF PATIENT IS A MINOR | |
|---|---|
| NAME: | NAME: |
| MAILING ADDRESS: | MAILING ADDRESS: |
| CITY – STATE – ZIP: | CITY – STATE – ZIP: |
| CELL PHONE: | CELL PHONE: |
| RELATIONSHIP TO PATIENT: | RELATIONSHIP TO PATIENT: |

Signature of Patient or Guardian: _____ Date: _____

Ver. 05/2019

# TEJAS HEALTH CARE

**1-844-TEJAS-4-U**

**WWW.TEJASHEALTHCARE.ORG**

890 E. Travis Street
La Grange, TX 78945

275 Ellinger Road
La Grange, TX 78945

185 Decker Drive
Giddings, TX 78942

## AUTHORIZATION TO RELEASE INFORMATION – HIPAA

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/ZIP: _____

The Health Information Portability and Accountability Act (HIPAA) allow patients to request a restriction regarding how information is disclosed.

I give permission to disclose my personal health information to the following person(s) stated below: (Example: Spouse, Relative, School)

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

---

## EMERGENCY CONTACT INFORMATION

Please list the family members or other persons, if any, whom we may contact in the case of an **EMERGENCY IN CARING FOR YOU.**

Name: _____ Telephone Number: _____

Relationship to patient: _____

---

## ACKNOWLEDGEMENT OR REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Tejas Health Care's Notice of Privacy Practices, which explains how my medical and psychological information will be used and disclosed. I understand that I am entitled to receive a copy of this document. This form was read by me or was read to me and I understand its meaning.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Print Name and Relationship of Person Authorized to Consent, if other than patient.

# TEJAS HEALTH CARE

1-844-TEJAS-4-U
WWW.TEJASHEALTHCARE.ORG

890 E. Travis Street
La Grange, TX 78945

275 Ellinger Road
La Grange, TX 78945

185 Decker Drive
Giddings, TX 78942

## PATIENT PHONE AND TEXT CONSENT

Patient Name: _____ Date of Birth: _____

Cell Phone Number: _____

I agree to be contacted by Tejas Health Care via phone, text, and/or email. Generally, text and email correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor. Examples of messages I might receive could include appointment reminders, service announcements, or general health education and awareness tips. These messages may contain information such as patient's name, appointment date, location, and provider name. Messages will never include actual lab or test results or diagnosis information. Additionally, email and text messages must never be used for results of testing related to HIV, sexually transmitted disease, hepatitis, drug abuse or presence of malignancy, or for alcohol abuse or mental health issues. Unless your provider tells you specifically that the test or email will be conducted via a secure server, consider email like a postcard that can be viewed by unintended persons. Email and text messages should be used only for non-sensitive and non-urgent issues. Types of information appropriate for email include:

- Questions about prescriptions
- Routine follow up inquiries
- Appointment scheduling
- Reporting of self-monitoring measurements

I understand that standard text message and data rates may apply under my cell phone service agreement but that Tejas Health Care will not charge a fee for this service. Message frequency is dependent on patient activity. Should I change my phone, cell, or email, I understand I am responsible for notifying Tejas Health Care of the change and for providing new information if I wish for the service to continue.

**I have read and understand the information above, and had any questions answered to my satisfaction. I agree to the guidelines for email communication. Accordingly: (Please choose one preferred method)**

- ☐ I hereby give my consent to receive text messages from Tejas (as per above number)
- ☐ I hereby give my consent to receive phone reminders or have reminders left on an answering machine from Tejas (as per above number)

_____ _____

Printed Name Date

_____

Signature of Requesting Patient/Representative (state relationship)

# TEJAS HEALTH CARE

1-844-TEJAS-4-U
WWW.TEJASHEALTHCARE.ORG

890 E. Travis Street
La Grange, TX 78945

275 Ellinger Road
La Grange, TX 78945

185 Decker Drive
Giddings, TX 78942

## PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES

Patient Name: _____ Date of Birth: _____

Welcome to Tejas Health Care. Our goal is to provide quality health care to qualified persons in this community, regardless of their ability to pay. As a patient, you have rights and responsibilities. Tejas Health Care also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide better health care for you. Please read and sign this statement and ask us questions you might have.

A. Human Rights

You have a right to be treated with respect regardless of race, color, marital status, religion, sex, national origin, ancestry, physical or mental handicap or disability, age (over 40), Vietnam era veteran status, or other grounds not permitted by applicable federal state and local laws or regulations.

B. Payment For Services

1. You are responsible for giving staff accurate information about your present financial status and any changes in your financial status. Tejas Health Care requires this information to calculate charges owed by you and/or to bill private insurance, Medicaid, Medicare, or other benefits for which you are eligible. If your income is less that the federal poverty guidelines, you may be charged a discounted fee.
2. You have a right to receive explanations of Tejas' bill. You must pay, or arrange to pay, all agreed fees for medical, services, with the exception of dental services which are provided on a prepaid basis. If you cannot pay right away please let staff know so they can provide care for you now and work out a payment plan.
3. Federal law prohibits Tejas from denying you primary health care health services which are medically necessary, solely because you cannot pay for these services.

C. Privacy

You have a right to have your interviews, examinations and treatment in privacy. Your medical records are also private. Only legally authorized persons may see your medical records unless you request in writing for us to show them to, or copy them for, someone else. A complete discussion of your privacy rights will be given to you along with this document and is named Tejas' Notice of Privacy Practices. Staff will request that you acknowledge your receipt of our Notice of Privacy Practices. The Notice of Privacy of Practices sets forth the ways in which your medical records may be used or disclosed by Tejas and the rights granted to you under the Health Insurance Portability and Accountability ("HIPAA").

D. Health Care

1. You are responsible for providing Tejas complete and current information about your health or illness, so that we can give you proper health care. You have a right, and are encouraged, to participate in decision about your treatment.
2. You have a right to information and explanations in the language you normally speak and in words that you understand. You have a right to information about your health or illness, treatment plan, including the nature of the reasonable alternatives, if any (and their risks and benefits); and the expected outcome, if known. This information is called obtain your informed consent.
3. You have the right to receive information regarding "Advance Directives." If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to your legally Authorized Representative.
4. You are responsible for appropriate use of center services, which includes following staff instructions, making and keeping scheduled appointments, and requesting a "walk in" appointment only when you are ill. Center professionals may not be able to see you unless you have an appointment. If you are unable to follow instructions from the staff, please tell them so they can help you.

5. If you are an adult, you have a right to refuse treatment or procedures to the extent permitted by applicable laws and regulations. In this regard, you have the right to be informed of the risks, hazards, and consequences of you refusing such treatment or procedures. Your receipt of this information is necessary so that your refusal will be "informed". You are responsible for the consequences and outcome of refusing recommended treatment or procedures. If you refuse treatment or procedures that your healthcare providers believe is in your best interest, you may be asked to sign a Refusal to Permit Medical Treatment or Services form or Against Medical Advice form (as appropriate).
6. You have a right to health care and treatment that is reasonable for your condition and within our capability, however, Tejas is not an emergency care facility. You have a right to be transferred or referred to another facility for services that Tejas cannot provide. Tejas does not pay for services that you receive from another healthcare provider.
7. If you are in pain, you have a right to receive an appropriate assessment and pain management, as necessary.

E. Center Rules

1. You have a right to receive information on how to appropriately use Tejas' services. You are responsible for using Tejas' services in an appropriate manner. If you have any questions, please ask us.
2. You are responsible for the supervision of children you bring with you to Tejas. You are responsible for your children's safety and the protection of other patients and our property.
3. You have a responsibility to keep your scheduled appointments. Missed scheduled appointments cause delay in treating other patients.

F. Complaints

1. If you are not satisfied with our services, please tell us. We want suggestions so can we can improve our services. Staff will tell you how to file a complaint. If you are not satisfied with how the staff handles your complaint, you may complain to Tejas' Governing Board.
2. If you complain, no center representative will punish, discriminate, or retaliate against you for filing a complaint, and Tejas will continue to provide you services.

G. Termination

If Tejas decides that we must stop treating you as a patient, you have a right to advance written notice that explains the reason for the decision, and you will be given thirty (30) days to find other health care services. However, Tejas can decide to stop treating you immediately, and without written notice, if you have created a threat to the safety of the staff and/or other patients. You have a right to receive a copy of Tejas' Termination of the Patient and Center Relationship Policy and Procedure.

Reasons for which we may stop seeing you include:

1. Failure to obey Center rules and policies, such as keeping scheduled appointments;
2. Intentional failure to report accurately your financial status;
3. Intentional failure to report accurate information concerning your health or illness;
4. Intentional failure to follow the health care programs, such instructions about taking medications, personal health practices, or follow up appointments, as recommended by your healthcare provider(s), and/or
5. Creating a threat to the safety of the staff and/or other patients.

H. Appeals

If Tejas has given you notice of termination of the patient and Center relationship, you have the right to appeal the decision to the Governing Board. Unless you have a medical emergency, we will not continue to see you as a patient while you are appealing the decision.

_____ _____

Signature Date