

Benjamin L. Nemeč, DDS

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Patient History

Patient Name: _____ Birth date: ____/____/____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Social Security #: _____ Driver's License _____
 Are you interested in receiving e-mail specials? Yes No
 E-Mail Address: _____
 Are you interested in receiving e-mail appointment reminders? Yes No
 If yes, please circle the best way to reach you: Home Phone Work Phone Cell Phone E-Mail

Please be aware that we strive to make your dental experience as comfortable as possible. With this in mind, we make every effort minimize any waiting time while you are with us. Dr. Nemeč and our staff dedicate time to you when you make an appointment with us. In order to maintain this level of service, we require 24 hours notice for appointment cancellations. *If you fail to provide us this courtesy, you will be charged a \$50 fee per hour of reserved time for your appointment.* Please help us to continue to provide the service that makes The Hills Dental Spa a unique dental experience. Thank you. _____ (Patient Initials)

Take your time to accurately complete this form. The information provided will be used as a reference so we may most effectively treat your dental health needs.

Please list any medications you are currently taking, all prescription, over-the-counter medication, vitamins & herbal remedies: _____

Please list drug allergies or allergic reactions you may have (medications, anesthetics, latex, etc.): _____

Have you ever been instructed to pre-medicate prior to your dental appointments? Yes No
 If yes, please explain: _____

Do you currently have, or have you had, any of the following conditions?

High Blood Pressure	Y N	Chemotherapy	Y N	Tuberculosis	Y N
Heart Attack/Angina	Y N	Radiation Therapy	Y N	AIDS/HIV	Y N
Mitral Valve Prolapse	Y N	Rheumatic Fever	Y N	STD	Y N
Heart Murmur	Y N	Diabetes	Y N	Hepatitis	Y N
Stroke	Y N	Eating Disorder	Y N	Pregnancy	Y N

Are there any other medical conditions or concerns you would like the doctor to be aware of?

_____ - Patient's Signature _____ - Date

Dental History

Patient Name: _____

Are you currently experiencing any problems or pain with your teeth and/or gums? If yes, please explain:

Toothache? _____ Broken Tooth? _____
Lost Filling? _____ Sensitivity to Hot? _____
Bleeding Gums? _____ Sensitivity to Cold? _____
Swelling? _____ Bad Breath? _____
Jaw/TMJ Pain? _____ Other Pain? _____

Do you have any other oral health concerns we need to be aware of? _____

Is there anything we should know that might make your visit with us more comfortable for you? _____

Please rate each of the following regarding your dental care by circling the appropriate level of importance to you:

<i>Preventive Dental Care</i>	Most Important	Very Important	Somewhat Important	Not Important	Unsure
<i>Excellence in Treatment</i>	Most Important	Very Important	Somewhat Important	Not Important	Unsure
<i>Freedom from Pain</i>	Most Important	Very Important	Somewhat Important	Not Important	Unsure
<i>Customer Service</i>	Most Important	Very Important	Somewhat Important	Not Important	Unsure
<i>Cost & Payment Options</i>	Most Important	Very Important	Somewhat Important	Not Important	Unsure
<i>Insurance Coverage</i>	Most Important	Very Important	Somewhat Important	Not Important	Unsure

Many people experience fear or anxiety when visiting the dentist. Please circle the level of fear you have about your dental visits (1 would be no fear at all, 10 would be the greatest fear):

1 2 3 4 5 6 7 8 9 10

Would you like to know about any of these services available to maximize your comfort during your dental visits with us?

Please check all that you are interested in learning more about:

- Music & headphones (what type of music do you like? _____)
- Cable television with viewing glasses
- Nitrous Oxide (commonly referred to as laughing gas)
- Sedative medication pills
- I.V. Sedation
- Patient education materials and videos about your treatments
- Massage

Please check any of the following that you are concerned about, or interested in:

- Replacing old silver fillings
- Recurring or untreated gum disease
- Receding gums
- Frequent headaches
- Snoring
- Discolored or damaged crowns
- Whitening your teeth
- Improving your smile
- Chronic tooth pain
- Other: _____

_____ - Patient's Signature _____ - Date

WHITENING PROCEDURE INFORMATION

- **Client Background** – It is essential that you, the client, provide complete and honest information when answering the questions about your dental history and health conditions. Dr. Nemec uses the information you provide to provide you with information about your professional teeth whitening procedure. We also provide you with this written information to give you insight about the treatment and what you can expect at your visit. The professional teeth whitening treatments that we utilize are very safe. Like all professional health care, there are limitations and risks which will be discussed in this literature. Furthermore, success is variable and cannot be guaranteed.
- **This Appointment** – Your visit today consists of a limited exam, which pertains only to cosmetic tooth whitening. You must understand that your visit does not include a comprehensive exam and you may presently have a dental condition or health concern that goes undetected during your visit. If any dental issues are noticed by Dr. Nemec, he will inform you; however, we insist you continue to see a dentist for at least annual checkups and for treatment of dental health conditions or concerns. If you do not have a dentist that you see regularly, we are happy to accommodate you at our office for general care and restorative dentistry, as well as the elective cosmetic procedures.
- **Candidates for Professional Whitening** – Your eligibility for treatment is determined through information gathered during the consultation and screening portion of your appointment. Many individuals will qualify for professional whitening treatment, but not everyone is deemed a candidate for this procedure. Dr. Nemec will discuss with you any findings during your consultation & may offer other alternatives for treatment to help you achieve the smile you desire.
- **Expectations of Professional Whitening** – Significant changes in whiteness can be achieved in many cases, but there is no definite way to predict how light your teeth will get. Candidates with a yellow or yellow-brown hue to their teeth tend to whiten better, or quicker, than people with a more grayish or gray-brown coloring. Teeth discolored by antibiotics, decalcification or white spots, root canal therapy, or trauma do not always respond as quickly or predictably as those with other types of staining. These conditions may require additional treatment or various procedures to attain a noticeably whiter appearance. On the other hand, if your teeth are already a light shade of white, your results from professional whitening could be minimal. Dr. Nemec will utilize a shade guide scale to show you the current coloring of your teeth and give you an idea of the type of results you can expect. We do not guarantee results, but his estimate will give you a good idea of what is possible today. The level of whiteness achieved varies from person to person and no two people will get the exact results. Our experience yields the average client an improvement of about 8 shades whiter, but you may or may not get results this extreme and there is no way to know for sure what your experience will be. During your consultation, be sure to ask questions if you have any and discuss your concerns with Dr. Nemec before any treatment is started.
- **Maintenance** – Within the first 24 to 48 hours after your treatment, it may appear that there is a slight change in the shade of your teeth. This is due to the reformation of a natural saliva coating that is removed from your teeth during the whitening treatment. Also, through the normal staining process of day-to-day eating and drinking, you may experience a slight regression of shade. This will be dependant on the frequency of your use of tobacco products, coffee, tea, red wine and other staining foods and drinks. You can reduce the amount of regression by utilizing a maintenance program. We recommend having your teeth professionally cleaned by a dental hygienist every 4 to 6 months which will not only keep your teeth and gums healthy, but will also remove minor

stains. Brushing your teeth at least twice daily, and ideally after every meal will help prevent new staining. We recommend using BriteSmile Whitening Toothpaste with an electric toothbrush such as those made by Oral-B. There are other brands of pastes and brushes available, but these are the ones Dr. Nemeč has found to be most effective for the majority of his clients. It is also very helpful to brush after a cup of coffee or tea, or a glass of red wine. These beverages are very staining and the more quickly you remove the colored particles from your teeth, the less staining you will have. If you can't brush your teeth after a meal or dark colored drink, try chewing a sugar-free gum. Spry Gum is a great choice that does not use artificial sweeteners, but any other brand would work well too. Chewing gum generates saliva which helps cleanse the teeth and removes some of the staining particles. If you use a mouthwash regularly, try a clear product such as BriteSmile, or use a lighter color in lieu of bright blue or green. And finally, for the longest lasting results, we recommend using an at-home treatment once a month. We recommend the BriteSmile To-Go pens because they are easy to use and not messy. Simply use the pen to paint whitening gel onto your teeth. Don't eat or drink for 30-minutes. Do this one day a month, in the morning and in the evening to remove minor stains - it's that simple. We can also make custom fitted trays for use with a whitening gel. You would squeeze the gel into your trays and wear them for 2 hours just one day a month. Our staff will be happy to show you the products we have available, or let you know what other products can be purchased at a drug store or grocery store.

- **Alternative Treatment Options** – After years in practice and experience with many whitening treatments, we offer the fastest, most effective means for most people to whiten their teeth. However, there are other treatment options available and we want you to be aware of all of your options. There are different in-office whitening procedures that utilize different ingredients and may use a different light source, or no light at all. There are also at-home treatments available. The at-home products purchased from a dentist office are a higher strength than the products purchased over-the-counter at a drug store. Some types of staining may require a treatment such as composite bonding to fully cover the stains. Or, a more long-term option for some people may be porcelain veneers or crowns. If you have questions about any of these alternative treatments, please talk to Dr. Nemeč before your whitening treatment begins. He can educate you about the differences and which other options may yield good results for your smile.
- **Potential Risks and Problems** – All forms of health treatment, including teeth whitening, have some level of risk and limitations. Complications that can occur in professional teeth whitening are generally infrequent and minor in nature. Please read all of this information carefully. If you have any questions or concerns about the potential risks, please ask Dr. Nemeč before you sign this consent form.
 - **Sensitivity** – During the whitening process, some patients experience sensitivity in their teeth. This sensation is usually mild if your teeth are not normally sensitive. If your teeth tend to be sensitive to hot or cold, or to the touch, please let us know before treatment begins so we can make certain adjustments designed to reduce the risk of sensitivity. We cannot predict whether you will have sensitivity during or after the treatment, and we cannot eliminate the risk of sensitivity. We may suggest taking a mild analgesic, such as Advil, before the procedure. Let us know right away if you have sensitivity or discomfort during your treatment. If your teeth do become sensitive during the procedure, or if any discomfort arises after the treatment, we have found that Tylenol or Advil often helps curb the sensation. Any sensitivity you may experience generally dissipates in 12 to 24 hours. If you have discomfort that lasts more than 24 hours, please contact our office.
 - **Gum or Soft Tissue Irritation** – Temporary inflammation of the gums and other soft tissues of the mouth may occur during your treatment. We take steps to minimize the likelihood of this, by using a protective material on your gums. Despite our efforts, some

people are overly sensitive to the ingredients in the protective material, or the whitening agent and irritation can occur. Stretching or irritation of the lips can also occur because of the use of the cheek retractor. This appliance is necessary to reduce the exposure of your cheeks to the active gel, but some people find it irritating. Any discomfort is generally very mild and only lasts an hour or two. If you do feel irritation in your lips, gums, or cheeks, rinse with warm salt water for relief. If discomfort persists for 24 hours or more, contact our office.

- Responsibilities** – You are responsible for asking questions if you have concerns before your treatment begins. If there is anything in this literature that you do not understand, or any questions you have that were not answered herein, you are encouraged to ask Dr. Nemeč or our staff for answers or further clarification. You are also responsible for following the directions you are given before, during, and after your treatment. Remember, there are many variables in professional whitening, but the information we provide to you is intended to help you be comfortable and achieve the best and longest lasting results possible.
- Confidentiality & Use and Disclosure of Information** – You have been informed that the information obtained by our office about your dental history and health conditions is treated as privileged and confidential. Your health concerns or conditions will not be shared with any party outside of our practice. We will photograph your smile before and after your whitening treatment. These photographs may be used to help other clients understand they type of results they may be able to expect from treatment. Your privacy will be protected and your name and contact information will not be shared.
- Authorization and Release** – By signing below, I certify that the information I provided to this office is accurate and complete to the best of my knowledge, information and belief. I have thoroughly read and understand the information contained in this document. I have had the opportunity to investigate the professional teeth whitening treatment and have had my questions answered to my satisfaction. I understand that results cannot be guaranteed and full payment is due at completion of treatment regardless of results achieved. There are no refunds and there will not be a claim filed to dental insurance for this treatment.

Signature of Client/Parent or Legal Guardian _____
Date ____/____/____

HOW DID YOU HEAR ABOUT BRITESMILE ? ••

TV Radio Newspaper Mail Magazine Website Friend Other _____

Additional Information: _____

Signature of Client _____ Date ____/____/____

Signature of Dentist _____ Date ____/____/____



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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 carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by Federal Law to give you this Notice and to maintain the privacy of your health information. We must also abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Protected Health Information

You will be asked to sign an Acknowledgement of Receipt of Notice of Privacy Practices. Once you have received our Notice of Privacy Practices, disclosure of your protected health information will be used for treatment, payment and health care operations. Your protected health information may be used and disclosed by our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of our practice. Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make:

Treatment - We will use and disclose your protected health care information to other dentists and physicians to provide, coordinate, or manage your health care. For example, your protected health care information may be provided to another dentist to whom you have been referred to ensure that the necessary information is available to diagnose or treat you. In addition, we may disclose your health information at times to a dental laboratory or specialist.

Payment - Your protected health information will be used to obtain payment for services we provide to you. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations - We may use or disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, credentialing activities, conducting training and conducting other business activities. For example, we may use a sign-in sheet at the front desk where you will be asked to sign your name when you arrive. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Business Associates - We will share your protected health information with third party Business Associates that perform various activities (billing or laboratory services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our practice has already taken an action as provided for in the authorization.

Other Permitted and Required Uses and Disclosures that May be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then we may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgement to make reasonable decisions in your best interest in allowing a person to pick up filled prescriptions, dental supplies, x-rays or other similar forms of health information.

Other Permitted and Required Uses and Disclosures that May be Made without Your Consent

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

Emergencies: We may disclose your health information in an emergency treatment situation. If this happens, we will try to obtain your Acknowledgement of Receipt of Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment. In the event of your incapacity or an emergency, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your health care.

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 the health or safety of others.

Military Activity and 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 institutions or law enforcement officials having lawful custody, the protected health information of inmates or patients under certain circumstances.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine compliance.

Your Rights

You have the right to inspect and copy your protected health information. 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 practically do so. You must make the 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 a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you prefer, we will prepare a summary of an explanation of your health information, for a fee.

You have the right to request a restriction of your protected health information. You have the right to request that we place additional restrictions on our use and 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.

You have the right to request alternative communications from us. You have the right to request that we communicate with you about your health information by an 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.

You have the right to request an amendment to your health information. You have the right to request that we amend your health information. Your request must be in writing. The request must explain why the information should be amended. We may deny your request under certain circumstances.

You have the right to receive an accounting of disclosures we have made of your health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain explanations, restrictions and limitations. 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.

You have the right to make a complaint about our privacy policies. If you are concerned that we have violated your privacy rights, you may file a complaint with our Privacy Officer using the contact information listed at the end of this Notice. You may also file a written complaint with the Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate against you for making a complaint to either our office or the Department of Health and Human Services.

You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this Notice electronically.

Privacy Practices effective: March 28, 2003

Privacy Officer: Amie Nemece

Telephone: 512-423-7825

Fax: 512-347-9844

E-Mail: Amie@TheHillsDentalSpa.com Address: 6836 Bee Caves Road, Suite 110, Austin, Texas 78746



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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Dr. Nemeč's Notice of Privacy Practices.
(print name)

Signature

Date: _____

For Office Use Only

Our office attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

- Patient refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other reason: _____

