



PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Form section for patient information including Last Name, First, Middle, Preferred Name, Marital Status, Birth Date, and Social Security Number.

Form section for Email Address and Cell Phone Number.

Form section for Address, City, State, Zip code, and Home Phone Number.

Form section for Occupation, Employer, and Employer Phone Number.

Form section for 'How did you hear about us?' with checkboxes for Family/Friend, Location, Google, Facebook, Other, Referred by Dr., Insurance Plan, and Hospital.

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Form section for Person Responsible For Bill, Birth Date, Address (if different), and Home Phone Number.

Form section for 'Is this person a patient here?' with Yes/No options.

Form section for Occupation, Employer, Employer address, and Employer Phone Number.

Form section for 'Is this patient covered by insurance?' with Yes/No options.

Form section for 'Please indicate primary insurance' with checkboxes for Delta Dental, Cigna, Met Life, Principal, Guardian, Blue Cross, Humana, Aetna, United Concordia, and Other.

Form section for Subscriber's name, S.S. no., Birth date, Group no., Policy no., and Co-payment.

Form section for Patient's relationship to subscriber with checkboxes for Self, Spouse, Child, and Other.

Form section for Name of secondary insurance (if applicable), Subscriber's name, Group no., and Policy no.

Form section for Patient's relationship to subscriber with checkboxes for Self, Spouse, Child, and Other.

IN CASE OF EMERGENCY

Form section for Name of local friend or relative (not living at same address), Relationship To Patient, Home Phone Number, and Cell Phone Number.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



Medical History

Are you under a physician's care now? No Yes
 Have you ever been hospitalized or had a major operation? No Yes
 Have you ever had a serious head or neck injury? No Yes
 Do you take, or have you taken, Phen-Fen or Redux? No Yes
 Are you on a special diet? No Yes
 Do you use tobacco? No Yes

List Medications _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

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

<input type="radio"/> AIDS/HIV Positive	<input type="radio"/> Cold Sores/Fever Blisters	<input type="radio"/> Hay Fever	<input type="radio"/> Liver Disease	<input type="radio"/> Sinus Trouble
<input type="radio"/> Alzheimer's Disease	<input type="radio"/> Congenital Heart Disorder	<input type="radio"/> Heart Attack/Failure	<input type="radio"/> Low Blood Pressure	<input type="radio"/> Spina Bifida
<input type="radio"/> Anaphylaxis	<input type="radio"/> Convulsions	<input type="radio"/> Heart Murmur	<input type="radio"/> Lung Disease	<input type="radio"/> Stomach/Intestinal Disease
<input type="radio"/> Anemia	<input type="radio"/> Cortisone Medicine	<input type="radio"/> Heart Pace Maker	<input type="radio"/> Mitral Valve Prolapse	<input type="radio"/> Stroke
<input type="radio"/> Arthritis/Gout	<input type="radio"/> Diabetes	<input type="radio"/> Heart Trouble/Disease	<input type="radio"/> Pain in Jaw Joints	<input type="radio"/> Swelling of Limbs
<input type="radio"/> Artificial Heart Valve	<input type="radio"/> Drug Addiction	<input type="radio"/> Hemophilia	<input type="radio"/> Parathyroid Disease	<input type="radio"/> Thyroid Disease
<input type="radio"/> Artificial Joint	<input type="radio"/> Easily Winded	<input type="radio"/> Hepatitis A	<input type="radio"/> Psychiatric Care	<input type="radio"/> Tonsillitis
<input type="radio"/> Asthma	<input type="radio"/> Emphysema	<input type="radio"/> Hepatitis B	<input type="radio"/> Radiation Treatments	<input type="radio"/> Tuberculosis
<input type="radio"/> Blood Disease	<input type="radio"/> Epilepsy or Seizures	<input type="radio"/> Hepatitis C	<input type="radio"/> Recent Weight Loss	<input type="radio"/> Tumor or Growths
<input type="radio"/> Blood Transfusion	<input type="radio"/> Excessive Bleeding	<input type="radio"/> High Blood Pressure	<input type="radio"/> Renal Dialysis	<input type="radio"/> Ulcers
<input type="radio"/> Breathing Problem	<input type="radio"/> Excessive Thirst	<input type="radio"/> Hives or Rash	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Yellow Jaundice
<input type="radio"/> Bruise Easily	<input type="radio"/> Fainting Spells/Dizziness	<input type="radio"/> Hypoglycemia	<input type="radio"/> Rheumatism	
<input type="radio"/> Cancer	<input type="radio"/> Frequent Cough	<input type="radio"/> Irregular Heartbeat	<input type="radio"/> Scarlet Fever	
<input type="radio"/> Chemotherapy	<input type="radio"/> Headaches	<input type="radio"/> Kidney Problems	<input type="radio"/> Shingles	
<input type="radio"/> Chest Pains	<input type="radio"/> Glaucoma	<input type="radio"/> Leukemia	<input type="radio"/> Sickle Cell Disease	

Have you ever had any serious illness not listed above? Yes No N/A _____

Dental Information

Reason for today's visit: Exam Emergency Consultation
 Are you in pain: No Yes How Long? _____
 Do you require pre-medication? No Yes Don't know

Please indicate any of the following problems:

<input type="radio"/> Discomfort, clicking or popping in jaw.	<input type="radio"/> Lost/Broken Filling(s)	<input type="radio"/> Stained teeth
<input type="radio"/> Red, swollen or bleeding gums	<input type="radio"/> Teeth grinding	<input type="radio"/> Locking Jaw
<input type="radio"/> Sensitive tooth – teeth or gums	<input type="radio"/> Ringing in Ears	<input type="radio"/> Bad breath
<input type="radio"/> Blisters/Sores in or around the mouth	<input type="radio"/> Broken/Chipped tooth	
<input type="radio"/> Other: _____		

Previous Dentist Name: _____ Phone (____) _____

Last Dental Exam: _____ Last Dental X-rays: _____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? Soft Medium Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

I hereby agree that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature: _____

Date: _____



Thank you for choosing Texas Dental for your dental needs. We are committed to providing you with excellent care and convenient financial terms. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities.

To confirm your understanding and agreement with our policies, please read and sign the following.

Payment:

Payment is due in full at the time of service. For your convenience we offer several payment options.

- Cash, Check, Visa, MasterCard, and Discover
- Extended payment plans provided through Care Credit and Springstone.

Insurance:

Our office is committed to helping patients maximize their benefits, however insurance policies vary greatly. Therefore, we can only ESTIMATE in good faith, not guarantee payment or coverage from your insurance carrier. Your estimated patient portion must be paid at the time service is delivered. As a courtesy to our patients, we will submit all Primary Dental Insurance claims to your insurance for payment, and allow 60 days for them to render funds. If your insurance does not pay for all anticipated fees or they do not render payment within 60 days, you will be responsible for the balance and it will be due in full. If you have any questions; our courteous staff is always available to assist you.

Missed Appointments:

Once an appointment has been made, please remember that this time has been reserved specifically for you. If you are unable to make your reserved appointment please provide our office 48 hours notice, so that our other patients may be given the same courtesy of utilizing the time should you be unable. We understand 48 hours notice is not always possible. However, if you do not show or reschedule your appointment less than 48 hours, two consecutive times we will be unable to reschedule your next appointment without a \$250 retainer fee. The \$250 will be allocated toward your treatment at the next scheduled appointment(s). If you do not show or reschedule your third consecutive appointment we will be unable to refund the money.

Specialty Services:

A 25% deposit is due at the time of appointment scheduling for all surgical and cosmetic procedures.

Service Charges and Collection Fees

A service charge of 1.25% monthly interest (15% annual percentage rate) or a billing charge will be applied to all accounts over 90 days past due. A \$40 fee will be applied to all returned checks. Any fees incurred to collect payment will be billed to and payable by the patient or guardian.

Financial Consent:

The patient or guardian agrees to be fully responsible for total payment of treatment performed in this office.

I understand and agree to this Financial Policy and Agreement.

Name of Patient (Please Print)

Name of Responsible Party (Please Print)

Signature of Responsible Party

Date



HIPAA Information and Consent Form

The health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14th 2003.

Patients of Texas Dental have rights as to who may see or be notified of their Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you and your family with quality professional service and care. Additional information is available from the U. S. Department of Health and Human Services (www.hhs.gov)

- Patient Information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, insurance payers, as is necessary and appropriate for your care.
- It is the policy of this office to remind patients of their scheduled appointments. We may do this by telephone, email, U.S. Mail, or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of office policy and new technology that you may find valuable or informative.
- The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payer in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.
- We agree to provide patients with access to their records in accordance with state and federal law.
- We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice
- You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Signature of Patient or Legal Guardian Date

Print Patient's Name

Print Name of Patient or Legal Guardian, if applicable