PATIENT REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Last Name:	First:	Middle:	Preferred Name:

❑Mr. ❑Mrs. ❑Ms.	Marital Status : Single / Married / Other : _____	Birth Date: _____/_____/_____	Social Security Number: _____-_____-_____

Email Address:	**Cell Phone Number**: ( )

Address:	City:	State:	Zip code:	Home Phone Number:

Occupation:	Employer:	Employer Phone Number: ( )

How did you hear about our office? (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Google Search	❑ Other:

Have you ever been a patient of Miranda Dental, PC (Texas Dental West) ❑Yes ❑ No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person Responsible For Bill:	Birth Date: / /	Address (if different):	Home Phone Number: ( )

Is this person a patient here?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer Phone Number: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Please indicate primary insurance	❑ Delta Dental	❑ Cigna	❑ Met Life	❑ Principal	❑ Guardian
❑ Blue Cross	❑ Humana	❑ Aetna	❑ United Concordia	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship To Patient:	Home Phone Number: ( )	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?	o No	o Yes
Have you ever been hospitalized or had a major operation?	o No	o Yes
Have you ever had a serious head or neck injury?	o No	o Yes
Do you take, or have you taken, Phen-Fen or Redux?	o No	o Yes
Are you on a special diet?	o No	o Yes
Do you use tobacco?	o No	o Yes

List Medications_____

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

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

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

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

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

Dental Information

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

Please indicate any of the following problems:

o Discomfort, clicking or popping in jaw.	o Lost/Broken Filling(s)	o Stained teeth
o Red, swollen or bleeding gums	o Teeth grinding	o Locking Jaw
o Sensitive tooth – teeth or gums	o Ringing in Ears	o Bad breath
o Blisters/Sores in or around the mouth	o Broken/Chipped tooth	

o 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? o Soft o Medium o 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, American Express, 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 24 hours notice, so that our other patients may be given the same courtesy of utilizing the time should you be unable. We understand 24 hours notice is not always possible. However, if you do not show or reschedule your appointment less than 24 hours, we reserve the right to charge a failed appointment fee for the time alotted.

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 b y 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