Registration History

PATIENT INFORMATION

NAME _____ DATE _____
Last First MI

BIRTHDATE _____ AGE _____ SS# _____
Month Day Year

DRIVER'S LICENSE # _____ ☐ MALE ☐ FEMALE / ☐ SINGLE ☐ MARRIED ☐ MINOR
(Please circle responses)

ADDRESS _____
Street Apt # City State Zip

TELEPHONE _____
Home Work Mobile/Alternate

E-MAIL ADDRESS_____

PLACE OF EMPLOYMENT _____

BUSINESS ADDRESS _____

PRESENT POSITION _____ YRS EMPLOYED _____

WHO MAY WE THANK FOR REFERRING YOU? _____

SPOUSE'S INFORMATION

SPOUSE'S NAME _____ DRIVER'S LICENSE # _____

BIRTHDATE _____ AGE _____ SS# _____
Month Day Year

EMERGENCY CONTACT INFORMATION

WHO SHOULD BE NOTIFIED IN CASE OF EMERGENCY? _____
Name Relationship to Patient Telephone Number

DENTAL INSURANCE INFORMATION

NAME OF INSURED/EMPLOYEE _____
Last First MI

INSURED SS# _____ BIRTHDATE _____

EMPLOYER NAME _____

DENTAL INSURANCE COMPANY _____

POLICY/GROUP # _____ TELEPHONE _____

CLAIMS ADDRESS _____

PLEASE LIST ALL COVERED FAMILY MEMBERS _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

AUTHORIZATION

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care for the purpose of treatment and administering claims for insurance benefits, including electronic submission of claims. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. Payment in full (or estimated co-payment and insurance assignment) is expected at the time of service. I attest that the information provided on this page is true and correct to the best of my knowledge.

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

HEALTH HISTORY

Patient's Name | Date of Birth | Date

My Chief Dental Complaint is:

Answer all questions by circling Yes (Y) or No (N) **All responses are kept confidential**

1. Are you in good health? Y☐N☐
2. Has there been any change in your general health in the past year? Y☐N☐
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? Y☐N☐
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe: Y☐N☐
   _____
   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Rheumatic Fever or Rheumatic Heart Disease? Y☐N☐
   - B. Congenital Heart Disease? Y☐N☐
   - C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y☐N☐
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y☐N☐
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness Y☐N☐
   - F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y☐N☐
   - G. Liver Disease (Jaundice, Hepatitis)? Y☐N☐
   - H. Kidney Disease? Y☐N☐
   - I. Diabetes? Y☐N☐
   - J. Thyroid Disease (Goiter)? Y☐N☐
   - K. Arthritis? Y☐N☐
   - L. Stomach Ulcers or Colitis? Y☐N☐
   - M. Glaucoma? Y☐N☐
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y☐N☐
   - O. Radiation (X-ray) treatment for Cancer? Y☐N☐
   - P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y☐N☐
   - Q. Sinus or Nasal problems? Y☐N☐
   - R. Any disease, drug or transplant operation that has depressed your immune system? Y☐N☐
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics? Y☐N☐
   - B. Anticoagulants (Blood Thinners)? Y☐N☐
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y☐N☐
   - D. High Blood Pressure medications? Y☐N☐
   - E. Steroids (Cortisone, etc.)? Y☐N☐
   - F. Tranquilizers Y☐N☐
   - G. Insulin or Oral Anti-Diabetic drugs? Y☐N☐
   - H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y☐N☐
   - I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax ,Actonel or Boniva for osteoporosis, or Aredia or Zometa for multiple myeloma, or other cancers) ? Y☐N☐
   - J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals: _____
     _____
     _____
9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)? Y☐N☐
   - B. Penicillin or other antibiotics? Y☐N☐
   - C. Sedatives, Barbiturates? Y☐N☐
   - D. Aspirin or Ibuprofen? Y☐N☐
   - E. Codeine or other pain killers? Y☐N☐
   - F. Latex or Rubber Products? Y☐N☐
   - G. Other allergies or reactions? Please, list Y☐N☐
     _____
     _____
10. Do you smoke or chew Tobacco? Y☐N☐
    How much per day? _____
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y☐N☐
12. Have you had any serious problems associated with any previous dental treatment? Y☐N☐
13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y☐N☐
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y☐N☐
15. Do you wish to talk to the doctor privately about anything? Y☐N☐
16. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant? Y☐N☐
    - B. Are you nursing? Y☐N☐
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date | Signature of Person Completing Health History | Doctor's Initial

Texas Dental Resources

What is the chance you will doze off in the following situations?

Sitting and Reading

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

Sitting and talking to someone

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

Watching TV

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

Sitting quietly after a lunch without alcohol

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

Sitting inactive in a public place, such as a theater or meeting

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

In a car, while stopped for a few minutes in traffic

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

As a passenger in a car for an hour without a break

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

TOTAL: _____

Lying down to rest in the afternoon when circumstances permit

- ◉ **0 - No Chance of Dozing**
- ○ **1 - Slight Chance of Dozing**
- ○ **2 - Moderate Chance of Dozing**
- ○ **3 - High Chance of Dozing**

Have you ever seen a sleep physician? Y ☐ N ☐
If so, when: _____

Have you had a sleep study performed? Y ☐ N ☐
If so, when: _____
Diagnosis: _____

Do you currently have a CPAP machine? Y ☐ N ☐

Do you use it every night? Y ☐ N ☐
If not, how often: _____

FINANCIAL POLICY

Thank you for choosing our office as your dental care provider. Our greatest concern is your complete oral health. Anything we do or say will be centered on that philosophy. It is suggested that each patient is seen every six months (or as needed) to ensure this preventative philosophy is met. We are committed to your treatment being successful, and to the return and maintenance of your good oral health. Please understand that payment of your bill is considered part of that treatment. The following is a statement of our **Financial Policy**, which we ask you read, and sign prior to any treatment.

PAYMENT FOR SERVICES RENDERED: You are responsible for payment of all services rendered on your behalf or your dependent. Payment is due at the time of service prior to you going to the back, unless other financial arrangements have been made in writing in advance.

INSURANCE ASSIGNMENT: We may accept assignment of insurance benefits; however, most insurance plans **do not** cover 100% of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, please keep in mind that some, and perhaps all, of the services are not considered reasonable and necessary under the provisions of your insurance plan. **If this office accepts your insurance company's assignment, it does not absolve your responsibility for the charges in full for the treatment rendered.** We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that company's assignment. If your insurance company has not paid your balance in full within 60 days, the balance will automatically be transferred to your account, and **you will be responsible for the balance owed**. This office cannot render services on the assumption that our fees will be paid by your insurance company.

INSURANCE FACTS: Some insurance companies set their fee schedule unrealistically low to limit the amount they must pay in benefits. This does not mean that our fees are too high. We set our fees according to a national dental fee survey. Most insurance companies have a yearly deductible. You will need to know what your deductible is and pay that amount before your insurance company will begin to pay benefits. Please be aware of any restrictions your insurance company has on benefits such as eligibility dates, benefit waiting periods, or necessary pre-certification, and notify the office prior to receiving treatment.

DEFAULT ON PAYMENT: In the event of default on payment, the patient or responsible party promises to pay a service fee of $11.00 and any attorney fees, as may be required to effect collection of this account. In addition, the patient or responsible party promises to pay a $30.00 service fee for all returned checks.

I have read and accept the terms of this Financial Policy as indicated by my signature below.

_____

Name of Patient(s)

_____ _____

Signature of Responsible Party Date Signed

_____

Print Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM
You may refuse to sign this acknowledgement but, in refusing we
will not be allowed to process your insurance claims.

Date: _____ Patient Email Address: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Texas Dental Resources, PLLC. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Relationship to Patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the above**

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ U. S. Mail
- ☐ **Any of the above**
- ☐ **NONE**

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment ☐
- I could not communicate with the patient ☐
- The patient refused to sign ☐
- The patient was unable to sign because ☐
- Other (please describe) ☐

_____
Signature of Privacy Officer