

# Patient Registration

First Name	MI	Last Name
Address		
City	State	Zip
Primary Phone	Secondary Phone	
Driver's License #	Email	
Birthdate	Social Security #	
Emergency Contact / Relationship	Phone Number	
Preferred Dentist	Preferred Hygienist	
Preferred Pharmacy	Pharmacy Number	

## Marital Status:

- Married
- Single
- Divorced
- Separated
- Widowed

## Gender:

- Male
- Female
- Unspecified
- Other \_\_\_\_\_

## Responsible Party (Same as Patient Yes or No)

First Name	MI	Last Name
Address		
City	State	Zip
Primary Phone	Secondary Phone	
Driver's License #	Email	
Birthdate	Social Security #	

## Who can we thank for your visit with us today?

- Drive/Walk By
- Insurance Company
- Another Office \_\_\_\_\_
- Patient Referral \_\_\_\_\_
- Other \_\_\_\_\_
- Online Search
- Mailer
- Radio
- Staff

## Primary insurance information

Policy Holder	Relationship to Patient
Insurance Company Name	Insurance Company Address
Insurance Company Phone	City, State, Zip
Employer Name	Employer Phone Number
Patient/Member ID	Group Number

## Secondary insurance information

Policy Holder	Relationship to Patient
Insurance Company Name	Insurance Company Address
Insurance Company Phone	City, State, Zip
Employer Name	Employer Phone Number
Patient/Member ID	Group Number

Student Status:  Full Time  Part Time

## Are there particular concerns you would like to discuss with the doctor?

- Toothache / Pain
- Removal of Wisdom Teeth
- Bridge / Partial / Denture
- Gum Bleeding / Pain
- Chipped or Cracked Tooth / Teeth
- Invisalign / Braces
- Implants
- Sedation Dentistry
- Other

## Additional Information/Comments:

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# Medical History

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

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 injury?

No  Yes \_\_\_\_\_

Are you on a special diet?

No  Yes \_\_\_\_\_

Do you take, or have you taken, Blood Thinners, Phen-Fen or Redux?

No  Yes \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

No  Yes \_\_\_\_\_

Do you use tobacco?

No  Yes \_\_\_\_\_

Do you use a controlled substance?

No  Yes \_\_\_\_\_

Are you taking any medication?

No  Yes Please list below

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

	Yes	No		Yes	No
AIDS / HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			

## Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Other \_\_\_\_\_

## Women, are you?

- Pregnant or Trying to Get Pregnant
- Nursing
- Taking Oral Contraceptives

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

FLOWER MOUND  
**FAMILY DENTISTRY**

# Notice of privacy practices

## Our legal duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you

Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we retain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## Uses and disclosures of health information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** we may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare operations:** we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation certification, licensing or credentialing activities.

Your authorization in addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: we must disclose your health information to you, as described in the Patient Right's section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your

healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons involved in care:** we may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures, in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing health-related services:** We will not use your health information for marketing communications without your written authorization.

**Required by law:** we may use or disclose your health information when we are required to do so by law.

**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, 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 your health or safety of the health or safety of others.

**National security:** we may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment reminders:** we may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

## Patient rights

**Access:** 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 a 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 you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you requested copies, we have the right to charge you \$0.05 for each page. \$15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies

mailed to you. If you request on alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your

health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Disclosure accounting:** you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. 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.

**Restriction:** you have the right to request that we place additional restrictions on our use of 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.

**Alternative communication:** you have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide a satisfactory explanation of how payments will be handled under the alternative means or location you request.

**Amendment:** you have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Electronic notice:** if you receive this Notice on our web site or by electronic mail (email), you are entitled to receive this Notice in written form.

## Questions and complaints

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**If you want more information about our privacy practices or have questions or concerns, please contact our office.**

# Use and Disclosure of Health Information Consent Form

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Patient Name

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Responsible Party

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Relation to Patient

Please read the following statements carefully.

By signing this form, you consent to the use and disclosure of your protected health information, including x-rays, photographs, and videos, to carry out treatment, payment activities, clinical review and training, and healthcare operations by our office.

**Notice of privacy practices:** You have the right to read our Notice of Privacy Practices before signing this Consent. Our Notice provides a description of our treatment, payment practices, clinical review and training, healthcare operations, of the uses and disclosures we may make of your protected healthcare operations, and of other important matters about your protected health information. A copy of this notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of this Consent or Notice of Privacy Practices at any time by contacting our office.

**Right to revoke:** You will have the right to revoke this Consent at any time by providing written notice of your revocation of this Consent. Your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. We reserve the right to decline to treat you or continue treating you if you revoke this Consent.

*By signing this consent form, I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, clinical review and training, and healthcare operations*

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Signature

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Date



# Financial Policy

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Patient Name

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Responsible Party

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Relation to Patient

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy which you need to understand prior to treatment. If you have any questions, please ask before signing.

**Full payment is due at the time of service. We accept cash, checks, and most major credit cards. There will be a \$35.00 fee on all returned checks. We reserve the right to charge for appointments canceled or broken without 24 hours advance notice.**

**Regarding insurance:** Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. All treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and copayments are due the day the treatment is rendered. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim.

**REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU ARE FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** Once a payment is received on your claim, we will send you a statement of any remaining balance on your account.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection for the balance.

*I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.*

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Signature

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Date

# Broken Appointment Policy

Reserved appointment time in our dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so may prevent other patients from receiving needed dental care in a timely fashion.

So that our dentists, staff, and patients will not be penalized by those who fail to keep scheduled appointments. Failure to keep a scheduled appointment without 24 hours advance notification will result in a \$35.00 for hygiene and a \$50.00 for doctor cancellation fee. That charge, in accordance with the broken appointment policy for all of our patients, is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the payment of the charge.

Please feel free to discuss this and other policies with our staff. Do not hesitate to ask if you have any questions.

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Signature

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Date

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FAMILY DENTISTRY