

PATIENT REGISTRATION

Welcome! Please complete the following confidential information

PATIENT INFORMATION

NAME _____
(First) (Middle) (Last)

SOCIAL SECURITY # _____ DATE OF BIRTH _____ Age _____ Sex: M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

HOME PHONE _____ EMAIL ADDRESS _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

IF PATIENT IS A MINOR, PARENT OR GUARDIAN'S NAME _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ DRIVER'S LICENSE NO. _____

EMPLOYER: _____ WORK PHONE _____ EXT _____

EMERGENCY CONTACT: _____ PHONE _____ RELATIONSHIP _____

HOW DID YOU HEAR ABOUT US? (CHECK ONE)

- Yellow Pages Family- Friend Flyer-Coupon Radio Office Sign Health Fairs Insurance Plan
 Internet Mail-Postcard Bill Board Employee Newspaper Other _____

DENTAL HISTORY

Reason for Visit / Main Concern? Check-Up Cleaning Toothache Other _____

Date of last dental visit _____ Reason _____

Have you ever had a bad experience in a dental office that you would like to tell us about? YES NO If yes, please explain _____

Does your gum bleed, feel tender or irritated? YES NO Are your teeth sensitive to hot, cold, sweets or pressure? YES NO

MEDICAL HISTORY

Are you under a Physician's care at this time? YES NO If yes, please specify _____

Name of Physician _____ Phone _____

What medications are you currently taking? _____

Are you taking any of the following? Warfarin Plavix Bisphosphonate Cortisone

If female, are you pregnant at this time? YES NO If yes, how many months? _____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING? (Check all that apply)

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer/ Leukemia | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Smoking Tobacco |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemo/ Rad Therapy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> AIDS/ HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis Type _____ | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |

Is there any other health problems not listed above of which we should be advised?

Please specify _____

Mark any of the following medications you are allergic to:

- Local Anesthetics Penicillin or other antibiotic Sulfa Drugs Aspirin Iodine
 Latex Codeine or other narcotics Barbiturates, sedatives Other _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Patient/Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental “clinic”. Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Morning appointments may be best for more complicated procedures.

Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!

Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of \$50 per hour of scheduled time for a broken appointment or cancellation with less than 24 hours' notice for your appointment. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee. Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the \$50 cancellation fee will be charged.

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Round Grove Family Dentistry' Appointment Cancellation Policy.

Signature of Patient/Guardian

Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- > Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment;
- > Obtaining payment from third party payers (e.g. my insurance company);
- > The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20 _____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Round Grove Family Dentistry
2325 S Stemmons Fwy Ste 301
Lewisville, TX 75067
469-702-2560

Insurance Payment Agreement

I, _____ understand that Round Grove Family Dentistry is accepting my insurance as payment for my/our dental services. However, I will be responsible for any services that my insurance does not pay.

Signed: _____

Date: _____

Acuerdo de Pago por Aseguranza

Yo, _____ entiendo que Round Grove Family Dentistry está aceptando mi aseguranza como un tipo de pago para mi/nuestros servicios. Yo seré responsable por cualquier servicio de cual mi aseguranza no se haga responsable.

Firma: _____

Fecha: _____