PATIENT REGISTRATION

Patient Information:

First Name:_____ Last Name:_____

Address:_____

City, State, Zip Code:_____

Home Phone:_____ Work Phone: _____

Cell Phone: _____ Referred by: _____

Email: _____ I would like to receive email correspondences: YES / NO

Social Security: _____ D.O.B: _____ DL#:_____

Emergency Contact: _____ Phone: _____

Sex: M or F Marital Status: single married divorced separated widowed partnered

Primary Insurance Information:

Name of Insured:_____ Relationship to Patient:_____

Insured's Employer:_____ Employer Phone:_____

Insurance Company:_____ Insurance Phone: _____

Please carefully read below: I, THE UNDERSIGNED HEREBY AUTHORIZE THE DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY THE DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENTS DETERMINED NEEDS. I ALSO AUTHORIZE DENTAL CONCEPTS TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION,THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK AND I UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND ME, AND BETWEEN THE INSURANCE CARRIERS AND DENTAL CONCEPTS, AND THAT I AM FULLY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I ALSO ASSIGN ALL INSURANCE BENEFITS TO DENTAL CONCEPTS AND PAYMENTS RECEIVED BY THE DOCTOR FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT AND WILL BE REFUNDED TO ME, UPON REQUEST, IF I HAVE PAID THE DENTAL FEES INCURRED. I FURTHER UNDERSTAND THAT AN ADDITIONAL CHARGE WILL BE ADDED TO ANY OVERDUE BALANCE. I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICE AS REQUESTED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA").

_____ _____

Patient Signature or Legal Guardian Date

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

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 ☐ Sulfa Drugs

☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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 OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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At Dental Concepts, we believe that you deserve the best care. In an effort to keep the costs down while maintaining a high level of professional care, we have established the following policy for our patients. We encourage you to discuss any questions you may have regarding our policies. Please initial by each line item.

_____* Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly.** Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you. We currently accept most insurance plans. Although we can maintain computerized histories of payment by a given company, they do change; therefore we cannot guarantee quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. Keep in mind this is not a guarantee of coverage. Verification of your benefits is based on the assumption that premiums are paid and up-to-date and that your employer has not initiated a current or back-dated cancellation of policy.

_____*If you have dental insurance, we will assist by determining the benefits and filing the claim on your behalf. **Your insurance policy is a contract between you and the insurance company;** therefore, it is important that you understand that if insurance companies pays only a portion of the bill or rejects your claim, **you are responsible for full payment for services rendered.** Conversely, if your insurance company pays above the projected estimation, you will receive a credit in that amount which may be withdrawn as a refund or applied to further treatment.

_____*Dental Concepts does require payment in full for your portion at the time of service unless prior financial arrangements have been made. Payments may be made by cash or credit card. All treatment requires an appropriate financial arrangement to schedule an appointment with the Doctor or Hygienist. **100% of your estimated patient portion will be collected at the time of scheduling.** Your Treatment counselor will be happy to discuss any questions and/or financial concerns regarding fees and payments. We offer financing through various lenders for your convenience.

_____* Your appointment is important to us. When you schedule the appointment, we reserve the Doctor's and Assistant's time and make preparation for your arrival. We strongly encourage all patients to keep their appointments. If you must change appointment, **we require at least 24 hour notice to avoid a $50 cancellation fee.**_____* In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call our office. **If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule, and the above cancellation fee will apply.**

_____* If my patient portion is not paid in full and my bill gets turned over to collections than I will be responsible for any and all collection charges and interest up to 18% A.P.R._____* **If in the future, I need a copy of the x-rays and/or records I do understand there will be a $25.00 service fee**. I also give my permission for Dental Concepts to email and/or fax copies of my x-rays and/or records to another office if needed for referral information.

_____*All accounts which have not paid the estimated portion of their bill at the time of service will incur a **$5.00 billing charge each month** until the balance is paid. Balances which are **60 days old or older will incur a monthly 1.5% finance charge** which equals an 18% per annum rate. There is also a $30 returned check fee.

_____*Any **account that has not received payment in 90 days will be handed over to a collection agency** that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

PLEASE READ THE FOLLOWING AUTHORIZATION AND SIGN FOR OUR FILES: I hereby authorize the release of any medical information necessary to process insurance claims. I authorize the payment of benefits to the Doctor described herein for services rendered. I have also read the above section on financial arrangements and agree to the terms.

_____

Signature of Patient or Parent/Legal Guardian

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 17, 2002 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

☐ I do NOT authorize any information to be discussed with any family members or friends.
☐ I authorize information about treatment or appointments to be discussed with the following person(s):

I have read and understand the Notice of Privacy Practices that was given to me from Dental Concepts.

_____
Patient name

_____ _____
Patient Signature Or Legal Guardian Date

ABOUT ME QUESTIONNAIRE

Patient Name: _____

Favorite Restaurant(s): _____
_____

Favorite Drink(s): _____
_____

Favorite Candy or Snack(s): _____
_____

Favorite Place(s) to Shop in Dallas/Fort Worth: _____
_____

Favorite Sports Team(s): _____
_____

Favorite Music: _____
_____

Favorite TV Show(s): _____
_____
_____

Favorite Book(s): _____
_____

Hobbies: _____
_____

Anything else you like or want DENTAL CONCEPTS to know about you:_____
_____

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New Patient Questionnaire -
Please circle all that apply and be specific if you circle other

Please take a moment to complete this survey so we can better understand your needs and concerns.

How often do you visit the dentist?

Every 6 months	Once a year
Once every two years	Once every 5 years
This is my first dental visit	Other:

What are some of your fears about going to the dentist?

Drills and needles	Pain and discomfort
No dental coverage	Too expensive
Too much work to be done	I have no fears
Time	Other:

Circle all that you are familiar with:

Fillings	Gum Disease	Dental Implants
Crowns	Bridges	Braces
Fluoride	Cavities	Root Canals

How confident are you about your smile? Ten being most confident:

1 2 3 4 5 6 7 8 9 10 Other:

Did you know that several studies have shown that periodontal disease is associated with heart disease and strokes? YES / NO

Do you want whiter teeth and a healthier smile? YES / NO

Do you have or have been told that you have bad breath? YES / NO

Do your gums bleed when you brush? YES / NO

Are you using an electronic tooth brush? YES / NO

Do you have sensitive teeth to hot/cold? YES / NO

Are you familiar with Dentures? YES / NO

Do you have crooked teeth or space between your teeth? YES / NO
If yes, is this something that bothers you and/or you would like to address?
YES / NO

What would you like to fix about you smile?

How do you feel about missing teeth?

Do you like telephone calls, postcards, or emails to remind you of your upcoming appointment?

What are some of your fears about going to the dentist?