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)

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

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: _____