3720 Gattis School Rd., Ste. 500 • Round Rock, TX 78664 | P: 512-494-4947
F: 512-494-4953
www.RedBudFamilyDental.com

Red Bud Dental Registration Form

Please Print Clearly

Patient Name: ______________________________ Preferred Name: ______________________

Sex: M / F (Circle one) Married: Single/Divorced/Widow/Child (Circle please)

Social Security Number: ________-________-________. Date of Birth: ______/______/________

Address:

Physical______________________________City:______________________ Zip:______________

Cell# (_____) ________-___________ Home# (_____) _______-_________

Email Address: ____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment reminders, administrative updates and health bulletins) Yes ( ) No ( )

HOW DID YOU HEAR ABOUT OUR PRACTICE?

____

PERSON RESPONSIBLE FOR PAYMENT FOR INSURANCE PAYMENT

Guarantor (Policy Holder) Name: _______________________Date of Birth: ___/______/_______

Relationship to patient: (Please check) ( ) Self ( ) Spouse ( ) Parent

Address (If different from patient):

Physical:____________________________City:________________________Zip: ______________.

Name of Insurance: ________________________________ Phone # of insurance: _____-_____-_______

Name of Employer: _________________________________ Group #:____________________________

Member ID number: _______________________________ or SSN# ____________________________

Who may call we in case of an emergency?

Name: __________________Relationship to patient: ___________________ Cell (_____)_____-_________

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y ( ) N ( )
IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Red Bud Dental. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: ____ Date: ____/_________/__________

Red Bud Dental Medical History Form

Name of Medical Doctor: ______________________ Phone: ____-____-______

List all medications or drugs you are currently taking:

( ) None

____

____

____

____

____

Check medications or drugs that you are ALLERGIC to:

( ) None

( ) Local Anesthetics	( ) Codeine / other narcotics	
( ) Aspirin	( ) Latex	( ) Metals
( ) Erythromycin	( ) Sulfa Drugs	( ) Cipro
( ) Penicillin	( ) Amox	( ) Epi
( ) Other:______________________		

Check any Medical Conditions you may have: ( ) None

( ) AIDS/HIV	( ) Emphysema	( ) Joint replacement, Date ____________
( ) Alcohol/Drug Abuse	( ) Epilepsy/Seizures	( ) Kidney/Bladder Trouble
( ) Anemia/Leukemia	( ) Fainting Spells	( ) Liver Disease
( ) Anorexia/Bulimia	( ) Frequent Headaches	( ) Low Blood Pressure
( ) Arthritis	( ) Frequently Dry Mouth	( ) Mental Health Problems
( ) Asthma/Hay Fever	( ) Fever Blister/Cold Sores	( ) Mitral Valve Prolapse
( ) Blood Clotting Problems	( ) Heart Attack/Stroke	( ) Persistent Diarrhea
( ) Bronchitis	( ) Heart Disease/Angina	( ) Rheumatic Fever
( ) Cancer/Tumor or growth	( ) Hepatitis/Jaundice	( ) Rheumatic Heart Disease
( ) Cardiac Pacemaker	( ) High Blood Pressure	( ) Sexually Transmitted Disease
( ) Chest Pain	( ) Hives/Skin Rash	( ) Sinus Trouble
( ) Damage Heart Valve	( ) High Cholesterol	( ) Thyroid Problems
( ) Diabetes	( ) Gall Bladder Issues	( ) Tuberculosis
( ) Other: ______________________		

Do you use Tobacco ? If so what kind and how much?

____.

Have you ever had any unusual reaction to DENTAL injections?

____.

The reason for today's dental visit?____.

New Patients:

Former Dentist: ______________Date of last cleaning and x/rays: ______________.

Are you interested in whitening your teeth?

____

By signing below, I certify all of the above information is true to the best of my knowledge.

______________________ ______________

Patient/Guardian Name (Printed) **Date:**

____

Patient/Guardian Signature

______________________ ______________

Witness Signature **Date:**

Office & Financial Policies

Please initial by each line and sign and Date the bottom

*Thank you for choosing us as your dental health provider. We are devoted to restoring and enhancing the natural beauty of your smile using conservative, state-of-the-art procedures that will result in a beautiful, healthy, and long lasting smile! Please take a moment to review the following office policies and **initial each one** as you read it. If you have any questions, please feel free to ask any staff member for more information*

APPOINTMENTS:

_______ *In order to provide you with the attention and level of care you deserve, we reserve a significant amount of time and reserve a specific room for your visit. We also understand that your time is valuable and, because of that, we make every effort to see you at the appointed time. On the other hand, your promptness and consideration in not changing your reserved time is very much appreciated. In the event you must change an appointment, a minimum 48-hour notice is required. **Please note that a fee of $30-$60 will be applied for appointments missed without notice and for broken appointments with less than 24 hours' notice.***

_______*Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.*

INSURANCE/FINANCIAL:

_______***Treatment Plan fees are valid for 90 days.***

_______*As a courtesy to our patients, we accept assignment of benefits from most insurance companies. However, **we do require you to pay your deductible and/or "estimated patient portion" at the time of service.***

_______*Your insurance company may pay alternate benefits for certain procedures such as bridge work. **Cosmetic restorations (white fillings), for example, are sometimes paid at a lower rate than our estimate. You will be billed for the remaining balance.***

_______*Some of our services may be "non-covered," subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations imposed by the insurance company. In addition, **there may be a missing tooth clause or other restrictions on your policy that may apply to your treatment and any subsequent payment expected from your insurance carrier.** Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive.*

You are responsible for the balance left unpaid by your insurance company.

_______*Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Any and all fees quoted for dental treatment are based on the current information provided to us by your insurance carrier. **Any differences in payments made by or procedures denied by your insurance carrier are your responsibility.***

_______***It is your responsibility to understand your dental insurance benefits and to inform the office of any changes to your insurance before treatment is performed.***

_______*The adult accompanying a minor is responsible for full payment.*

_______***In the event your account balance remains unpaid in excess of 90 days, your account will be turned over to a collection agency with 100% interest. You will be fully responsible for all admin costs and legal fees associated with the collection process.***

Thank you for reviewing and understanding our guidelines. Please let us know if you have any questions or concerns.
I have read, understand, and agree to the above policies.

_______________________________________ ______________________

Patient's Signature – (or Legal Guardian's) Signature ***Date***

____

Witness's Name – Please print *Witness's Signature* *Date*

Red Bud Dental 3720 Gattis School Rd Ste 500 Round Rock, TX 78664 Ph#512-494-4947 Fax 512-494-4953

ACKNOWLEGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have read a copy of the office's Notice of Policy Practices (copies given upon request Thanks)

____

Patient Name (printed)

____

Signature of patient (Guardian)

____

Date