**Red Bud Dental Medical History Form List all medications or drugs you are currently taking: Check medications or drugs that you are ALLERGIC**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( None)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Local Anesthetics ( ) Codeine / other narcotics

( ) Aspirin ( ) Latex ( ) Metals

( ) Erythromycin ( ) Sulfa Drugs ( ) Cipro

( ) Penicillin ( ) Amoxicillin ( ) 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 ( ) Frequent 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

( ) PREGANT or NURSING ( ) Have you been hospitalized or had any major operations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever taken Fosamax, Boniva, Actonel or any other meds containing bisphosphonates?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Dental History**

( ) Dental Anxiety ( ) Grinding of teeth ( ) Sensitivity to cold

( ) Bad Breath ( ) Gums swollen or tender ( ) Sensitivity to cold

( ) Bleeding gums ( ) Jaw pain or tiredness ( ) Sensitivity to sweets

( ) Burning sensation on tongue ( ) Loose or broken teeth ( ) Pain with chewing or biting

( ) Chew on side of mouth ( ) Mouth Breathing ( ) Sores or growths in mouth

( ) Clicking or popping jaw ( ) Mouth pain/brushing ( ) Interested in cosmetic Dentistry

( ) Cheek biting/or Lip ( ) Orthodontic treatment ( ) Periodontal treatment

( ) Food Collection between teeth ( ) Pain around ear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) Fingernail Biting ( ) Tobacco Use? What kind? \_\_\_\_\_\_\_\_\_\_\_\_Quantity?\_\_\_\_\_\_

The reason for today's dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Former Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last cleaning and x/rays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Guardian Signature Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

\_\_\_\_\_\_\_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.

\_\_\_\_\_\_\_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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian Date:

 **Red Bud Dental Registration Form**

 **Please Print Clearly**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Sex: M / F (Circle one) Married/Single/Divorced/Widow

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address: (City State and zip)**

Cell# (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Home# (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

HOW DID YOU HEAR ABOUT OUR PRACTICE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person responsible for payment and Insurance Information**

Guarantor (Policy Holder) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_

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

**Address (If different from patient):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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 hereby grant permission to (Red Bud Dental) to use photographs and/or video of me taken on (date) at (location) in publications, news releases, online, and in other communications related to the mission of (Red Bud Dental). YES ( ) NO ( )**

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 3720 Gattis Scholl Rd Ste 500 Round Rock, TX 78664 PH 512-494-4947 Fax 512-494-4953

**ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES**

 **\*\*\*You May Refuse to sign this Acknowledgement\*\*\***

**I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and received a copy of the Office’s Notice of Practice Policy. (Copies available upon request)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient (Printed Name) Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient (Guardian) Date:**