Patient Registration and Dental/Medical History Form

Patient Information

PRINT FULL NAME (First, Full Middle Name, Last Name) DATE OF BIRTH

STREET ADDRESS

CITY STATE ZIP

SOCIAL SECURITY NUMBER DRIVER'S LICENSE NUMBER / ISSUING STATE PHONE NUMBER

OTHER OR FORMER NAMES (aka, maiden names, married names, surnames, etc.) EMAIL ADDRESS

PLACE OF EMPLOYMENT OCCUPATION

Emergency Contact Information

Full Name: ____________________________Relationship: ___________________________

Street Address: ____City: __________________ State: ______ Zip: __________

Home Phone: _____________________ Cell Phone: ____________________ Work Phone: ______________________

Primary Insurance Information

Subscriber: _____________________ Subscriber ID Number: _______________________ Subscriber DOB:____________________

Group Number: _______________ Insurance Company Name: ______________________ Phone Number: ____________________

Secondary Insurance Information

Subscriber: _____________________ Subscriber ID Number: _______________________ Subscriber DOB: _____________________

Group Number: _______________ Insurance Company Name: ______________________ Phone Number: _______________________

How did you hear about us?

Internet __________________________________ Patient Referral: __________________________________

Other ____________________________________

Dental History

Purpose of this appointment: _______________________________ Problems/Concerns: ____

Date of **YOUR** last dental visit/cleaning: __________________ Are you happy with your smile?____

Do you currently have any dental pain? ___Yes ___No Explain:____

Have you ever had unhappy dental experiences? ___Yes ___No Explain:____

Have you ever had any injuries to your mouth/teeth/head? ___Yes ___No Explain:____

Do you mouth-breath/snore? ___Yes ___No Explain:____

Do you have any jaw issues (clicking/popping/pain)? ___Yes ___No Explain:____

Do you wear orthodontic (braces) appliances? In the past? ___Yes ___No Explain:____

Dental Hygiene Routine

How many times per day do you brush? ___________

Do you use fluoridated toothpaste? ____Yes ____No

Do you use a manual or an electric toothbrush? ____________

Do you floss? ____Yes ____No

How many times per week do you floss? _______________

Do you use mouth rinse? ____Yes ____No Type:_________

Medical History

Physician's Name: ____________________________ Date of Last Medical Visit: ____

Street Address: ________________________________ City: ___________State: ___ Zip: __________ Phone: _____________________

Are you currently under a doctor's care for a specific reason? __Yes __No Explain: ____

Are you currently taking any medications? ___Yes ___No Explain: ____

Do you have any emotional/mental conditions we should be aware of? ___Yes ___No Explain: ________________________________

Do you have any physical conditions we should be aware of? ___Yes ___No Explain: ____

Do you have any medical conditions we should be aware of? ___Yes ___No Explain: ____

Are you allergic to any medications? ___Yes ___No Explain: ____

Do you have any other allergies (food/animals/latex/local anesthetics, etc.)? ___Yes ___No Explain:_____________________________
____

Have you ever been hospitalized? ___Yes ___No Explain: ____

Have you had any surgeries? ___Yes ___No Explain: ____

Do you require pre-medication before dental treatment? ___Yes ___No Explain: ____

WOMEN ONLY: Are you or could you be pregnant? ___Yes ___No Taking Birth Control Pills? ___Yes ___No

Have you ever had or experienced any of the following? **(Check all that apply)**

- __AIDS/HIV
- __Anemia
- __Arthritis
- __Asthma
- __Autism
- __Bladder Infection
- __Bleeding disorder
- __Blood Transfusions
- __Blurred Vision
- __Cancer/Tumors
- __Excessive Thirst
- __Dry Mouth.
- __Frequent Urination
- __Difficulty Urinating
- __Cerebral Palsy
- __Chemotherapy
- __Radiation Treatment
- __Sinus Problems
- __Chest Pain (angina)
- __Persistent Cough
- __Bleeding Problems
- __Frequent Headaches
- __Diabetes
- __Diarrhea
- __Eye disease(s)
- __Eating Disorder
- __Epilepsy
- __Earaches/Ringing
- __Fainting/Dizziness
- __Seizures
- __Vomiting/Nausea
- __ADD/ADHD
- __Joint Replacement
- __Headaches
- __Hearing Loss
- __Heart Murmurs
- __Heart Disease
- __Heart Attack
- __Heart Defects
- __High Blood Pressure
- __Hemophilia
- __Hepatitis A/B/C
- __Herpes
- __Kidney Infection
- __Liver Infection
- __Mouth Sores/Ulcers
- __Organ Transplant
- __Pacemaker
- __Prosthetic Heart Valve
- __Psychiatric Care
- __Rheumatic Fever
- __Thyroid Problems
- __Shortness of Breath
- __Swollen Ankles
- __Difficulty Swallowing
- __Stroke/Hardening of Arteries
- __Sexual Transmitted Disease(s)
- __Stomach Problems/Ulcers
- __Tobacco in any form
- __Alcohol
- __Contact Lenses

ALL PATIENTS:
Do you have any other medical information that we need to be aware of that has not yet been covered in this form? ___Yes ___No
Explain: ____
____

Appointment Policy

Your scheduled appointments are reserved specifically for you. Any late arrivals or missed appointments affect many patients, including your own appointment. It may be several weeks before we are able to reschedule the appointment. We have listed our "Appointment Policies" below:

- If a cancellation is unavoidable, please call our office at least **24 hours in advance** at (214)823-2182 so that we may give your appointment time to another patient. If a cancellation is made with less than 24 hours' notice, this may be considered a missed/broken appointment.
- We require a **VERBAL CONFIRMATION** in order to hold your reserved appointment. Failure to do so may result in forfeiting your appointment time to a patient who is on our appointment waiting list.
- If you fail to arrive for your scheduled appointment without notice, this may be considered a missed/broken appointment.
- Please arrive at least 5 minutes early for your appointment. If you arrive more than 15 minutes late for your appointment, it may need to be canceled due to scheduling restrictions. This appointment may be considered a missed/broken appointment.
- A missed/broken appointment may result in a $50.00 charge for failure to cancel/reschedule the appointment in a timely manner. It is the discretion of HF Dental whether or not this charge will be applied.
- **Three missed/broken appointments** may result in the termination of our dentist-patient relationship.

I understand that the information given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand that it is my responsibility to inform Henderson Family Dental of any changes in my medical status, insurance and/or contact information. I also understand Henderson Family Dental's late/canceled/failed appointment policy.

Printed Name: ____ Date: __________________________

Signature: ____

Henderson Family Dental
Patient Financial Agreement

Read the following and initial the line that best represents your insurance and/or financial responsibility.

______ I do not have an insurance carrier and understand payment is due in full at time of service.

_______I would like the doctor's staff to bill my insurance as a courtesy to me. I understand that my estimated patient portion is due at the time of service, and after insurance pays, any balance remaining is due immediately.

Understanding the Insurance Process

Contracted Insurance

- Our office is NOT contracted with every insurance company.
- If contracted, we accept the insurance company's negotiated/allowable fees.

Non-Contracted Insurance

- Our office will bill and accept payment from many non-contracted PPO insurance companies.
- Patients are responsible for the difference between our fee and the insurance company allowable fee.
- Insurance companies use their Fee Schedule (NOT Dr. Nguyen's fee schedule) when paying a claim.
- Subscribers can request a copy of the fee schedule from the insurance company; our office cannot.

Policy Deductibles – Deductibles must be paid before the insurance company will pay benefits.

Maximum Benefits - Insurance companies pay no more than the policy maximum benefit. Patients are responsible for any balance over the maximum benefit.

FILING AN INSURANCE CLAIM IS NOT A GUARANTEE OF PAYMENT. AFTER THE INSURANCE PAYS, ANY BALANCE REMAINING IS DUE IN FULL

Missed/Cancelled Appointments without a 24-hour notice will be charged a $50 cancellation fee. All future appointments will be charged a $50 deposit. The deposit will be credited toward your treatment that day; if you fail to give a 24-hour notice to cancel the appointment you will forfeit the deposit.

Circle your method of payment:

Cash Visa MasterCard American Express CareCredit

Please ask your treatment coordinator for more information on any of these payment options. Balances after 90 days from the date of treatment will accrue finance charges at 18% APR. Patients are responsible for all finance, rebilling, collection and attorney costs on any unpaid balances.

______________________________ ______________________________
Patient Name (Print) *Responsible Party Name (Print)*

______________________________ ______________________________
Patient or Financially Responsible Adult Signature *Date*

______________________________ ______________________________
Witness Signature *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW THIS 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 HIPPA, 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 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 including the business aspects of running out 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 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 judgement, your consent 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 abode by that written request, expect 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 agree 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 a notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of May 10, 2010 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 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 of 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 and 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 filling 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 following person(s) :

____

Patient Signature or responsible party   Date