A+ Family Dental

Creating Beautiful Smiles!!!

17748 Katy Freeway, St 5, Houston, TX 77094
Phone: (281) 646-1133
Fax: (281) 646-1152

PATIENT REGISTRATION FORM

Patient Name		Referred By	
Residence Address	City	State	Zip
Telephone	E-mail Address		
Other Family Members in the Practice	Preferred Time for Appointments		
SSN - -	DOB / /		
Marital Status S M D W	Spouse's Name		
If Minor, Name of Guardian	Address & Telephone		
Person Responsible for Fee (if other than patient)	Relationship to Patient		
Billing Address (if different than above)			
Occupation	Will you receive calls at work? Yes No		
Employer's Name & Telephone			
EMERGENCY NOTIFICATION Name & Telephone			

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Name of Insurance Company		
Address		
Telephone		
Subscriber's Name / Relationship to Patient	/	/
Name of Group Policyholder or Union		
Group Policy / Individual Policy #	/	/
Effective Date / Time Limit for Claims	/	/
Pre Estimate Required	____ Yes ____ No	____ Yes ____ No
Method of Payment	____ UCR ____ Schedule of Payments ____ Other	____ UCR ____ Schedule of Payments ____ Other
Coinsurance	Company_____ % Patient_____ %	Company_____ % Patient_____ %
Deductible	____ Yes ____ No ____ Individual ____ Family Annual $_____ Lifetime $_____	____ Yes ____ No ____ Individual ____ Family Annual $_____ Lifetime $_____
Plan Covers Orthodontics	____ Yes ____ No	____ Yes ____ No
Other		
If Paying by Credit Card	Name of Card	
	Card #	Expiration Date

Medical History

INSTRUCTIONS

"I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission."

Patient's Initials_____ Dentist's Initials_____

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write "N/A" (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is "Permission to Release Information." You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

1. Name, address & phone # of your physician _____
2. Date of last visit to your doctor _____ Purpose of visit _____
3. Do you suffer from any disability? _____ If yes, describe _____
4. Have you ever, or do you now take illegal drugs? _____ If yes, what drugs, and when taken? _____

   Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____
6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe. _____
7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____
8. For females: Are you pregnant? _____ If yes, when are you due? _____
9. For females: Are you taking birth control pills? _____
   Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.
10. List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each.

    Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.
11. Have you ever had an allergic reaction to medication? _____ If yes, describe. _____
12. Have you lost weight recently? _____ If yes, describe. _____

Have You Ever Had Or Been Treated For:

13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____
15. Stomach or intestinal disease? _____

Medical History [continued]

16. Abnormal blood pressure, excessive bleeding, or anemia? _____
17. Breathing problems, asthma, tuberculosis, or hay fever? _____
18. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment? _____
19. Diabetes? _____
20. Kidney problems or renal dialysis? _____
21. A stroke, convulsions, or fainting spells? _____
22. Tumors or growths? _____
23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ If yes, describe. _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____
26. Are you on a special diet? _____ If yes, for what reason and describe. _____
27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, when and describe.
29. Do you consume any alcoholic beverages? If yes, how much and how often? _____
30. Are there any other problems about your health of which you are aware? _____
31. For children under 10 years old: Was the child born by Cesarean Section? _____
32. Females: Are you currently taking any bisphosphonate medication? _____
33. Have you had any prosthetic joint replacement? _____
34. Are you allergic to latex? _____
35. Do you ever notice that your feet and/or ankles are swollen? _____
36. Are you aware of any swollen glands in your neck? _____

Dental History

1. Name of previous dentist _____ Date of your last visit _____
2. Reason for your last visit (or series of visits) _____
3. Do you have any of your X-rays or dental records? _____
4. Chief dental complaint if any? _____

In respect to any previous dental treatment have you:

5. Ever fainted? _____
6. Had an allergic reaction? _____
7. Had abnormal bleeding? _____
8. Any other complications during or following dental treatment? _____ If yes, describe. _____
9. Do your gums bleed on brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____

Dental History [continued]

12. Are any of your teeth sensitive to heat, cold, or pressure? _____
13. Do you grind your teeth or clench your jaws? _____
14. Do you have pain or clicking in the jaw joint in front of your ear? _____

_____

15. Have your jaw muscles ever been sore? _____ If yes, describe._____

_____

16. Are there any sores or growths in your mouth? _____

_____

17. Do any of your teeth ache? _____
18. Do you have any other dental complaint? _____

_____

To the best of my knowledge, the foregoing questions have been accurately answered.

NOTE: A change in your health status should be reported to the office immediately.

"I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time."

Patient's Initials_____ Dentist's Initials_____

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or health practitioners.

Person completing the form: _____ Signature_____

Witness _____ Print Name_____

If other than patient, indicate relationship_____Date_____

Dentist's History Review & Significant Findings: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: Dr. _____ Date: _____

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FINANCIAL AGREEMENT

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they individually have purchased, will pay for all their treatment. This is incorrect and untrue.

As a **courtesy** to our patients we are willing to complete insurance forms and submit a claim on your behalf, however **we are not responsible for the outcome of the transaction**. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement.

We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office and gives us your permission to release information to the insurance company.

We require you to pay the estimated co-payment, at time of service. In the event your insurance company fails to pay for treatment you received, **you are responsible for the entire balance to be paid within sixty days of your visit.** You would then be responsible for seeking reimbursement from your insurance company.

We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

It is the patient responsibility to pay any outstanding dues to the office upon completion of the treatment, otherwise the collection fees and the associated legal fees, if any, will have to be borne by the patient.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____
Print Name of Patient/Responsible Party

_____ Date_____
Signature of Patient/Responsible Party

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Broken Appointment Policy

We work hard to meet and accommodate the needs of all our patients and we are dedicated to providing you with the best dentistry and service available.

Time is specifically reserved for you on our schedule. Therefore, when sufficient notice is not given to cancel or change an appointment, it does not give us enough time to contact another patient on our waiting list who would benefit from coming in earlier.

If you do need to cancel an appointment, 48 hours notice (business hours) is required to prevent a broken appointment charge of $25 per appointment, from being applied to your account and due immediately.

We do understand that emergencies come up and illnesses occur and will take that into consideration. For your convenience, we do have an answering machine available if you need to call after hours to cancel an appointment.

I, _____, understand and agree with the above office policies.
(PLEASE PRINT PATIENT NAME)

_____ _____

Patient Signature/Guardian Signature Date

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HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize A+ Family Dental and associates 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. insurance company)**
- **Day-to-day healthcare operations of the practice (email/text reminders/confirmations of appointments via online services)**

I have also been informed of, and given the right to review, 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 HIPAA. I understand that A+ Family Dental reserves 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 this 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 healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

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 _____, ___.

Patient Name Printed: _____

Signature: _____ Relationship to Patient: _____

TREATMENT PLAN

DIAGNOSIS	TREATMENT PLAN	FEE	EXT DATE
1			
2			
3			
A-4			
B-5			
C-6			
D-7			
E-8			
F-9			
G-10			
H-11			
I-12			
J-13			
14			
15			
16			
17			
18			
19			
K-20			
L-21			
M-22			
N-23			
O-24			
P-25			
Q-26			
R-27			
S-28			
T-29			
30			
31			
32			
PROPHY			
PERIO			
F/F			
P/P			
RELINE			
X-RAYS, EXAM			
	TOTAL		

INFORMATION

PATIENT INFORMATION

PATIENT ACCOUNT#	ACCT. TYPE	CLINIC
NAME		
ADDRESS		APT #
CITY	STATE	ZIP
HOME PHONE	BUSINESS PHONE	
BIRTH DATE	SOCIAL SECURITY #	
EXAM BY DR.	EXAM DATE	DA
DR. SIGNATURE		
PATIENT SIGNATURE		

FINANCIAL ARRANGEMENTS

CREDIT ☐ YES ☐ NO

INSURANCE COVERAGE ☐ YES ☐ NO

THIS DOES NOT AFFECT METHOD OF PAYMENT

ESTIMATE OF BENEFITS

PATIENT'S PORTION $_____

INSURANCE ESTIMATE $_____

EQUAL PAYMENT PLAN

_____ @ $ _____

OTHER

DOWN PAYMENT $ _____

TREATMENT BY APPOINTMENT

APPT. NO.	SERVICES TO BE RENDERED	$ AMT. OF SERVICE	DATE RENDERED

PROGRESS NOTES

PATIENT' S NAME ______________________ CHART No. ________ Age ______ Page No. ________

DATE	CODE	TOOTH #	SUR-FACE	*NOTES*	SERVICE	PAYMENT	BALANCE