PATIENT REGISTRATION

ID: _____ Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic:

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: Pref. Dentist: _____

Employer ID: Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Cell Phone: _____

Credit Card #: _____

Driver License #: _____

Pharmacy #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____ .00

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

HIPPA Consent

I understand that under the Health Insurance Portability and Accountability (HIPPA) Act of 1996, I have certain rights regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments.
4. The day-to-day healthcare operations of the practice.

I have also been informed of and given the right to review and secure a copy of Houston Texas Dental Spa's 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 Houston Texas Dental Spa reserves the right to change the terms of this notice from time to time and that I may contact the office 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 health care operations, but that Houston Texas Dental Spa is not required to agree with these requests. However, if both parties do agree, they 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 revoked this consent is not affected.

Name: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES FORM

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

The Health Insurance Portability and Accountability (HIPPA) Act of 1996 is a federal program that required that 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, as the patient, significant rights to understand and control how your health information is used. HIPPA provides penalties for concerned 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, payment and health care options.

1. Treatment means providing, coordinating or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
2. 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.
3. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. An example would be an internal quality assessment review.
4. We may also create and distribute health information by removing all references to individual identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment or health care operations in the following circumstances:

1. In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
2. If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent.
3. 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 to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about your 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 abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following right with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. 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.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.
7. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of the date it is signed, 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 our information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a formal, written complaint with our office or the Department of Health and Human Services. Please contact the 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 filing a complaint.

Name: _____

Signature: _____

Date: _____

TREATMENT CONSENT FORM

What you are being asked to sign is a confirmation that we have discussed the nature and purpose of dental treatment, the known risks associated with dental treatment, the feasible treatment alternatives and that all your questions have been answered in a satisfactory manner. Please read this form carefully before signing and ask about anything you do not understand.

My signature at the bottom of this form certifies that:

I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.

I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.

I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there may be additional fees.

I understand that Dr. de Jongh and his staff have carefully examined my mouth and recommended what the best possible form of treatment. Alternative treatment plans have been explained and I have been informed and understand the purpose and nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of any necessary prosthesis.

I have been informed of the possible risks and complication involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip,tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.

I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications nay necessitate further treatment.

I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also possible are temporomadibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and muscle fatigue when chewing.

Dr. de Jongh and his staff have explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.

I agree to follow the home care instructions provided to me. I agree to report to Dr. de Jongh for regular examinations as indicated and I understand that this office will monitor my progress unless I have been advised to return to my general dentist for care.

To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust and blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I consent to photography, study models and x-rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my best to remove the bacterial plaque off all the surfaces of my teeth and/or prosthetics every day. If I do not clean my dentition properly, I may get decay and/or gum disease and my treatment may fail.

I understand that it is my responsibility to comply with recommended treatment protocol and return in a timely fashion for any follow up appointments necessary to complete treatment. If I fail to do so, my treatment may be terminated at the discretion of the Houston Texas Dental Spa. I understand that I am not entitled to a refund for any work that has been initiated.

I understand and authorize the taking of clinical photographs and videos for educational, scientific and/or marketing purposes, both in publications and presentations. I hold Houston Texas Dental Spa harmless for any liability resulting from this production. I waive my rights to any royalties, fees and inspection of the finished production as well as advertising materials in conjunction with these photographs.

I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment. I also state that I read and write in English.

Name: _____

Signature: _____

Date: _____

OFFICE FINANCIAL POLICY AGREEMENT

It is our belief that all of our patients deserve the best possible dental care we provide. Part of that care is that making necessary financial arrangements prior to beginning treatment so that the treatment plan selected can move forward without hesitation. We feel that everyone benefits when office policy and financial arrangements are clearly understood. In keeping with this belief of ensuring all parties have a definitive understanding of payment for dental services provided, the following is the Houston Texas Dental Spa office financial policy.

We offer three convenient payment methods to assist our patients:

1. Payment in full at the beginning of the appointment during which services are rendered. We accept cash, check, Visa, Mastercard or American Express.
2. No interest payment plan options for 6 months through Care Credit or Lending Club.
3. Extended payment plan options through Care Credit or Lending Club.

As a courtesy to you, our office will be happy to file your claim with your insurance company or provide the forms for you to do so yourself. Please note that all payments made for services that have been initiated are non-refundable, and it is your responsibility to complete treatment in a timely fashion. Should a patient fail to complete treatment in a reasonable amount of time or comply with recommended treatment protocol, Houston Texas Dental Spa reserves the right to terminate treatment at our discretion with no refund. Full fees may be requires to initiate treatment at a later date.

I understand that I am responsible for payment of all fees at the beginning of the appointment during which serves are rendered, regardless of insurance coverage, including any legal and/or other costs incurred in the collection of this account, should it become delinquent.

I have read the above policies and accept responsibility of payment for any work incurred at this office.

Name: _____

Signature: _____

Date: _____

RESCHEDULING POLICY AGREEMENT

We appreciate you business! In an effort to best serve all out patients, please be advised of these policies:

Arrival Time: Please aim to arrive 10-15 minutes prior to your scheduled appointment time. If you arrive after your scheduled appointment time, it may not be possible to extend the time available for your booked service, and on some occasions rescheduling may be necessary. If your service is shortened due to your late arrival, you will still be charged the full cost of the service.

Changing Your Appointment: Houston Texas Dental Spa requires 24 hours' notice to reschedule or cancel a booked appointment, except in rare cases of emergency and/or contagious illness as described below. If you fail to notify our office more than 24 hours ahead and/or miss your appointment without proper notification, you will be charged a $50 fee for the failed appointment. Please be aware that we do not accept appointment changes or cancellations via email or text message.

Sickness or Family Emergency: If you, or another person in our household have an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date.

Please be courteous and take a few moments to notify our office in a timely fashion regarding any changes in your schedule and we will be happy to make accommodations to assist you when possible.

Name: _____

Signature: _____

Date: _____