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

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:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

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: Rem. Deduct:

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: Rem. Deduct:

Time 11:34 AM | Maria Perez DDS | Date 1/12/2015

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

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

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

Have you ever had any serious illness not listed ○ Yes ○ No If yes

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:

X Date:_____

DEERBROOK FAMILY Dentistry
20440 Hwy 59 N, Suite 300, Humble, TX 77338
281-548-0008
Fax: 281-548-0238
Info@Deerbrookfamilydentistry.com

General Consent

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I can submit to procedures in all phases of dentistry including periodontics (gums treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges and dentures), dental implant, restorative dentistry, temporomandibular disorder treatment, treatment of sleep apnea, oral pathology, pediatric dentistry and the x-ray.

2. I am going to provide a thorough and complete medical history, provide a full list of my medications with dose and consent to my dentist to communicate with my other doctors to ask about any aspect of my medical history.

3. No guarantees can be made about the results of the treatment, the restoration of the longevity, or prognosis. I understand that any branch of medicine, including dentistry can produce unexpected results.

4. I will pay in full any cost of treatment or insurance copayments according to the office policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any cost that my insurance does not cover.

5. My treatment plan may change at any time and I will make my best effort to approach my dental care with optimism and open communication with my dentist, dental hygienist, and the staff of the office.

6. I am welcome to ask about any aspects of my dental care and request information if I am confused or need more information. I am responsible to clarify any aspect of my treatment that I am unsure about.

_____	_____	_____
Patient Name (Please Print)	Signature of the patient, legal guardian Or Authorized Representative	Date

_____
The name and the relationship to the patient

DEERBROOK FAMILY Dentistry
20440 Hwy 59 N, Suite 300, Humble, TX 77338
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Office Policy

Payment for Services:

Payment is expected at the time of your services. We accept cash, Visa, MasterCard, American Express, Discover, CareCredit and Citi Healthcard. We do not accept personal checks. Any unpaid balance over 90 days will be considered delinquent and turned over to a collection agency. Fees may apply.

Dental Insurance:

We will be happy to submit an insurance claim for you as a courtesy. It is your responsibility to inform us of any changes in your insurance carrier or policy. If your insurance company denies your claim, we expect payment of the full balance within 10 days of the notice you receive from your insurance company. Professional services are rendered to a person, not to the insurance company. **Our treatment is based on the dental need of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company**. We will help in any way possible to file your claim or handle any insurance queries you may have. It is your responsibility to be involved with your insurance company. **The patient is responsible to the doctor and the insurance company is responsible to the patient.**

Consent:

I authorize release of any information and/or x-rays relating to my dental treatment to the insurance company, attorney or collection agency in collecting the full cost of the services provided.

I authorize release of any information and/or x-rays to offices where I have been referred.

Appointments:

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please notify us at least **48 hours** in advance. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a $25 charge for not showing up for scheduled appointments. ***Repeated cancellations or missed appointments will result in the loss of future appointment privileges.***

Saturday Appointments:

An appointment reservation deposit of $200, regardless of insurance benefits, is required when scheduling an appointment on a Saturday. This deposit is non-refundable if the appointment is missed.

By signing below, you have read and agree to our Office Policy.

_____	_____	_____
Patient's name (please print)	Signature of patient, legal guardian or authorized representative	Date

_____
Name and relation to patient

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Deerbrook Family Dentistry 20440 Hwy 59 N Suite 300

Acknowledgment

I, _____, hereby acknowledge that I have received and reviewed a copy of Deerbrook Family Dentistry's HIPAA Notice of Privacy Practices.

I understand that Deerbrook Family Dentistry's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Deerbrook Family Dentistry's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Deerbrook Family Dentistry's HIPAA Notice of Privacy Practices, I may contact Crystal Pardini at 281-548-0008

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Deerbrook Family Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Deerbrook Family Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Crystal, noted above, for assistance.

_____ Patient Signature	_____ Date
_____ Signature of Personal Representative	_____ Print Name of Personal Representative
	_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Deerbrook Family Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Deerbrook Family Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

DEERBROOK
FAMILY DENTISTRY

Name: _____ Date: _____

Please tell us how you learned about our practice. (Select ALL that apply)

_____Friend/Family Name: _____

_____Staff member Name: _____

_____Other dentist/doctor Name: _____

_____Our website

_____Internet search Search Engine: _____

_____Insurance Company Insurance Company: _____

_____Office Sign/Window

_____Referral Card

_____Direct Mail Post Card

_____Smile Savings Program

_____Brochure

_____Drive by

_____Other: _____