Patient Registration

Patient Information:

First name and middle initial: ____

Last name: ____

Preferred name or nickname: _______________________________________

Date of birth: ____

Address: ____

City, State, Zip: ____

Best daytime phone number: _(____)-______-____________, Extension: _______

Cell phone number: _(____)-______-______________________

Home phone number: _(____)-______-________________________

Email address: ____

Who is the insurance policy holder for this patient? ____

Social security number for the insurance policy holder: ______________________________

Date of birth for the insurance policy holder: _______________________________________

Emergency contact name and phone number: ____

Responsible party (if someone other than the patient):

First name and middle initial: ____

Last name: ____

Address, if different from above: ____

City, State, Zip: ____

Best daytime phone number: _(____)-______-____________, Extension: _______

Cell phone number: _(____)-______-_____________________________________

Email address: ____

MEDICAL HISTORY

Patient Name: ___________________________
Birth Date: ___________________________
Today's 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.

Do you have a primary care doctor? Please list name and phone number:	Yes	No	If yes: ______________________________
Have you been hospitalized or had a major operation in the last 5 years?	Yes	No	If yes: ______________________________
Have you ever had a serious head or neck injury?	Yes	No	If yes: ______________________________
Have you ever taken medication for osteoporosis or cancer?	Yes	No	If yes: ______________________________
Are you on a special diet?	Yes	No	If yes: ______________________________
Do you use any form of tobacco?	Yes	No	If yes: ______________________________
Do you snore or stop breathing while sleeping?	Yes	No	If yes: ______________________________
Do you need Pre-Med before dental treatment?	Yes	No	If yes: ______________________________
Do you use controlled substances?	Yes	No	If yes: ______________________________
Do you experience frequent anxiety?	Yes	No	If yes: ______________________________
Are you taking any medications, pills, or drugs?	Yes	No	If yes: ______________________________

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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 Anesthetic

Do you have, or have you had, any of the following? If yes, please check all that may apply:

__AIDS/HIV Positive	__Hemophilia	__Radiation Treatments	__Alzheimer's Disease
__Diabetes	__Recent Weight Loss	__Anaphylaxis	__Hepatitis B or C
__Renal Dialysis	__Anemia	__Easily Winded	__Herpes
__Angina	__Emphysema/COPD	__High Blood Pressure	__Arthritis/Gout
__Epilepsy or Seizures	__High Cholesterol	__Artificial Heart Valve	__Excessive Bleeding
__Hives or Rash	__Shingles	__Artificial Joint	__Excessive Thirst
__Hypoglycemia	__Sickle Cell Disease	__Asthma	__Fainting Spells/Dizziness
__Irregular Heartbeat	__Sinus Trouble	__Blood Disease	__Kidney Problems
__Blood Transfusion	__Leukemia	__Stomach/Intestinal Disease	__Breathing Problems
__Frequent Headaches	__Liver Disease	__Stroke	__ Bruise Easily
__Low Blood Pressure	__Swelling of Limbs	__Cancer	__Glaucoma
__Thyroid Disease	__Chemotherapy	__Mitral Valve Prolapse	__Tonsillitis
__Chest Pains	__Heart Attack/Failure	__Osteoporosis	__Tuberculosis
__Cold Sores/Fever Blisters	__Heart Murmur	__Pain in Jaw Joints	__Tumors or Growths
__Congenital Heart Disorder	__Heart Pacemaker	__Ulcers	__Convulsions
__Heart Trouble/Disease	__Psychiatric Care	__Drug Addiction	__HPV

Have you had any serious illness not listed? If yes, please explain:

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To the best of my knowledge, the questions on this form have been accurately answered.
I understand that providing the 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: ______________________________

HIPAA Consent Form

Our Privacy Policy provides information about how we may use and disclose protected health information about you. Please ask for a copy of the policy if you would like to read it before signing this consent. The policy contains information describing your rights under the law and is provided in order to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA). You have the right to review our policy before signing this consent. The terms of our policy may change. You may obtain a revised policy at the practice.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. The practice is not obligated to agree to those restrictions requested.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. This includes use in obtaining payment from insurance providers and for consultations and referrals involving medical doctors and/or dental specialists. You have the right to revoke this consent, by making a request in writing, except for information already used or disclosed.

List the names of those who can have access to your medical information, for example, a spouse, parent, or caregiver. They can be given limited access, such as billing only.

Name: ___________________________ Full access or partial access: _____________________

Name: ___________________________ Full access or partial access: _____________________

Signature of patient or legal guardian: _____________________________ Date: ___________

If refusing to sign - staff and one witness must sign below

Staff signature: _____________________________ Date: _______________________

Witness signature: __________________________ Date: _______________________

Third Coast Family Dental

Financial/Cancellation Policy and Consent to Dental Treatment

We offer the following payment options:

- Cash or check
- Visa, Mastercard, Discover, American Express
- Care Credit (third-party financing for healthcare)

Your dental benefits **are determined by your employer and the amounts paid out sometimes vary** due to limitations, allowed fee schedules, used deductibles, and yearly maximums. We make every possible effort to generate an accurate estimate of this for you in advance, however, the insurance company and your employer make the final determination. **The benefits we investigate on your behalf are only estimates.**

All copayments (patient portion) are the responsibility of the patient and are due at the time of your appointment/treatment. Any billed amounts denied by insurance are the patient's responsibility for payment.

Third Coast Family Dental is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. **We work hard to honor your appointments and hope that you will commit to do the same.**

Please call us by 2:00 pm two days prior to your scheduled appointment to notify us of any changes or cancellations. **To change a Monday appointment, please call our office by 2:00 pm on Thursday.** This allows us enough time to ensure another patient can be offered that time in the schedule. **If advance notification is not given, you will be charged $25 for the appointment.**

If we are unable to reach you for confirmation, **your appointment may be removed from the schedule.** Your consideration in promptly replying via text confirmation, email confirmation or by returning a phone call is very important and much appreciated.

I understand the above information and have had the opportunity to ask questions. I hereby consent to be seen as a patient at Third Coast Family Dental, and agree to the recommended diagnostic procedures, including but not limited to radiographs, photographs, and a comprehensive examination.

Patient or parent/guardian signature: ____________________________________

Date: ___________________

Printed name of patient: ____