DALLAS FAMILY *Dental*

PATIENT REGISTRATION

TELL US ABOUT YOURSELF

Name _____ Date _____
First Last

Preferred Name _____ SSN _____

Birthdate ____/____/____ Gender _____

Marital Status ☐ Married ☐ Single ☐ Child ☐ Other: _____

Phone _____ Email _____

Address _____

How did you choose our office? _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____ SSN _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____ SSN _____

Policy Owner's Employer _____

EMERGENCY CONTACT

Name _____

Relationship _____ Phone _____

SPOUSE OR PARENT INFORMATION

Name _____ Phone _____

Birthdate ____/____/____ SSN _____

Relationship _____

Do you have legal custody of this child if patient is a minor? ☐ Yes ☐ No

DENTAL INFORMATION RELEASE

I give Dallas Family Dental permission for my Protected Health Information to be disclosed to family or others. This may include, but is not limited to; examination and treatment rendered, diagnosis, detailed treatment plans, accounting, insurance claims and billing. The release of information will remain effective until terminated by myself in writing. This information may be released to the following individuals:

☐ Spouse or parent

☐ Child(ren)

☐ Other _____
Name

☐ Information is not to be released to anyone other than myself.

_____
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Dallas Family Dental's Notice of Privacy Practices. (You may refuse to sign this acknowledgement.)

Print Name _____

_____
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify) _____

AUTHORIZATION

I authorize the Doctor to take any diagnostic aids he/she deems necessary to make a thorough diagnosis of my dental needs and to perform any and all forms of treatment, medication and therapy that may be indicated utilizing assistance as appropriate. I authorize Dallas Family Dental to release any information including the diagnosis and/or records of treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I understand that my dental insurance may pay less than the actual fee for services and that I am responsible for payment of all services/fees rendered, regardless of insurance coverage, on my behalf and that of the dependents on the account. I agree to pay the expected patient portion at the time services are rendered unless other financial arrangements have been made in advance.

_____
Signature Print Name Date

Main reason for today's visit _____ Date of last dental visit _____

Previous dentist _____ City/State _____

DENTAL HISTORY

Mark "YES" or "NO" to indicate if you have, or have had, any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Bleeding gums	☐	☐	Foreign objects	☐	☐	Pain around ear
☐	☐	Bad breath	☐	☐	Grinding teeth	☐	☐	Periodontal treatment
☐	☐	Blisters on lips or mouth	☐	☐	Gums swollen or tender	☐	☐	Sensitivity to cold
☐	☐	Burning sensation on tongue	☐	☐	Jaw pain or tiredness	☐	☐	Sensitivity to heat
☐	☐	Cigarette, pipe, or cigar smoking	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to sweets
☐	☐	Clicking or popping jaw	☐	☐	Loose teeth or broken fillings	☐	☐	Sensitivity when chewing
☐	☐	Dry mouth	☐	☐	Mouth breathing	☐	☐	Sores or growths in your mouth
☐	☐	Fingernail biting	☐	☐	Mouth pain while brushing	☐	☐	Unable to chew on one side of mouth
☐	☐	Food collection between teeth	☐	☐	Orthodontic treatment			

How often do you: Floss? _____ Brush? _____

HEALTH HISTORY

Mark "YES" or "NO" to indicate if you have, or have had, any of the following:

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

Have you ever had any serious illnesses not listed? ☐ Yes ☐ No If yes, please explain _____

WOMEN

Are you pregnant? ☐ Yes ☐ No Due Date _____ Are you nursing? ☐ Yes ☐ No Birth control pills? ☐ Yes ☐ No

MEDICATIONS

Please list any medications you are currently taking _____

ALLERGIES

☐ None ☐ Aspirin ☐ Barbiturates ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Other

Have you ever been hospitalized or had any surgeries? ☐ Yes ☐ No If yes, please explain with reason and dates _____

Physician _____ Phone _____ Last Appointment _____

To the best of my knowledge,all of the preceding answers are true and correct. I will not hold this office responsible for errors or omissions that I may have made in the completion of this form. If my health history changes, I will notify this office at my next dental appointment.

Signature of Patient, Parent, or Guardian _____ Date _____

PATIENT NAME _____

Please initial that you have read and understand each section.

_____ **Financial Policy**

I have received the Dallas Family Dental Financial and Insurance Policy that outlines my financial responsibility toward care rendered by the doctors at Dallas Family Dental. I understand that the guarantor on the account will be responsible. If my child has an appointment the guarantor on the account will be responsibe for payment at the time services are rendered.

_____ **Appointment Cancellation or No-Show Policy**

I take full responsibility for the cancellation/rescheduling of any needed appointments. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, WE REQUIRE AT LEAST A 24 HOUR NOTICE PRIOR TO YOUR APPOINTMENT TIME to avoid a $45 cancellation fee. Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. Dallas Family Dental reserves the right to dismiss the patient from the practice after 3 missed or late cancelled appointments.

_____ **Medical/Dental Release Statements**

I give my consent for the doctors of Dallas Family Dental to complete a thorough examination on myself or the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform Dallas Family Dental of any future changes to my or my child's medical history status. I also hereby grant the doctors and staff of Dallas Family Dental permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

_____ **Insurance Claim Release & Financial Responsibility Statement**

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance company. I am aware that Dallas Family Dental will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

_____ **Authorization for Direct Payment**

I hereby authorize payment of insurance benefits directly to Dallas Family Dental or the dentist that performs my treatment. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_____ **Notice of Privacy Practices, Health Insurance Portability & Accountability Act of 1996**

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my confidential health care information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Dallas Family Dental from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.

_____

Signature of Patient, Parent, or Guardian Date

PATIENT NAME _____

FINANCIAL POLICY AND INSURANCE INFORMATION

Methods of Payment

For your convenience we accept cash, check, and all major credit cards (Visa, MasterCard, American Express and Discover). We gladly offer and accept payment plans through CareCredit for dental treatment.

As we strive to be one of Dallas' leading providers for family dental care, we work to assist patients in taking an active role in their dental health. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursement.

At each visit, we will request a copy of your dental insurance information to allow us to file your claim. Please remember to bring all dental insurance information/insurance card(s) to each appointment. Please contact Dallas Family Dental immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your or your child's exam, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your ESTIMATED out-of-pocket portion for the treatment plan. We will discuss all treatment options and costs before beginning any further treatment. We know that dental insurance can be confusing so feel free to contact us with insurance or payment questions.

Dental Insurance

We are dedicated to providing all our patients with the best treatment available and base all our treatment recommendations on what will be best for you or your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.

2. As a courtesy, we will be happy to file for your insurance benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. **In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.**

3. **Any amount not covered by your insurance company is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child may not be covered by your specific dental insurance. Our primary goal is to treat you and your child using the best possible materials, supplies, medications and environment.

4. We allow a maximum of 45 days for your insurance company to clear account balances. **Any unpaid portions will be due in full, by you, after this period.** If you have not paid your balance within 60 days of the date treatment was rendered, a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you. This is rare but is important that you recognize that your insurance is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately you are responsible for all charges incurred in our office.

5. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (estimated patient portion or EPP). Please remember, this is only an estimate based upon generalized information provided by your dental insurance company. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your oral health!