PATIENT REGISTRATION

Full Name: ______________________________________ **Preferred Name**: ________________ **Date:** _____________

Date of Birth: __________________ **Age**: ______ **Sex**: M ____ F ____ **Social Security**: ____________________

Address: ____________________________________ **City** _______________ **State** ________ **Zip**___________________

Phone Number: _____________________________ **Email:** ____

Drivers License: ____________________ **Marital Status**: □ Single □ Married □ Divorced □ Separated □ Widowed

<u>Language Preference</u>: Spanish ___ English ___

<u>Emergency Contact</u>: *Name* _____________________________________ *Phone Number* _________________________

Whom may we thank for referring you to our office?: ____

When was your last visit to the dentist (approximately): ____

<u>Responsible Party</u> (if someone other than patient is financially responsible for treatment)

Full Name:____ DOB: ___/___/_____

Relationship To Patient: ____

<u>Communication Consent</u>:

May we send you Text Messages: ___ **YES** ___ **NO**

May we leave voice messages: ___ **YES** ___ **NO**

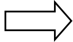
- Are you having pain or discomfort at this time?............................. □ Yes □ No
- Do you feel nervous about having dental treatment?.................... □ Yes □ No
- Would you be interested in a simple way to whiten your teeth?.... □ Yes □ No

Privacy practice acknowledgment:

I have received the Notice of privacy practice act and I have been provided the opportunity to review it.

Consent for Dental Exam and X-Rays.

I, the undersigned, voluntarily consent to authorize the dental provider(s) and dental clinic professionals and staff who may be involved in my care to provide such examinations, diagnosis, care and treatment considered necessary or advisable by my dental provider.



___________________________________	_____________________________	__________________
Patient or Parent Name (Print)	Patient or Parent Signature	Date

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answer 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 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
Have you ever had trouble getting numb or had any reactions to local anesthetic?..... □ Yes □ No

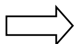
WOMEN: Are you pregnant/ trying to get pregnant? YES / NO Taking oral contraceptives? YES / NO Nursing? YES / NO

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Local Anesthetic
□ Other: ____

***Circle** any of the following you have had or have:*

AIDS/HIV	Diabetes	Hemophilia	Recent weight loss
Anaphylaxis	Drug Addiction	Hepatitis: A B C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or seizures	High Cholesterol	Scarlet fever
Artificial Heart Valve	Excessive bleeding	Hives or rash	Shingles
Artificial Joint	Excessive thirst	Hypoglycemia	Sickle Cell disease
Asthma	Irregular Heartbeat	Sinus trouble	Fainting Spells/ Dizziness
Blood Disease	Frequent coughs	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid disease
Chemotherapy	Hay Fever	Mitral valve prolapse	Tonsillitis
Chest Pains	Heart Attack/ Failure	Osteoporosis	Tuberculosis
Convulsions	Heart murmur	Pain in jaw joints	Tumor Growths
Heart trouble	Parathyroid disease	Ulcers	Congenital Heart Disorder
Heart Disease	Psychiatric care	Venereal Disease	Cold Sores/Fever Blisters
Cortisone Medicine	Heart Surgery	Radiation treatments	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes__ No__ If yes:________________________________


______________________________ ______________________________ ________________
Patient or Parent Name (Print) Patient or Parent Signature Date

FINANCIAL AGREEMENT AND INSURANCE INFORMATION

INSURANCE INFORMATION

1 - Do you have**: PRIMARY DENTAL INSURANCE?** **Yes** ____ **No**____ If yes, **Name**: _________________________

Primary Subscriber Full Name:____ DOB: ___ /___ /_____

Member ID or SSN: ______________________ Employer Name: _______________________ Group No.: ___________

Insurance Phone Number: ___________________ Relationship To The Subscriber: ○ Self ○ Spouse ○ Child/Dependent

2 - Do you have: **SECONDARY DENTAL INSURANCE?** **Yes** ____ **No**____ If yes, **Name**: _________________________

Primary Subscriber Full Name:____ DOB: ___ /___ /_____

Member ID or SSN: ______________________ Employer Name: ________________________ Group No.: ___________

Insurance Phone Number: ___________________ Relationship To The Subscriber: ○ Self ○ Spouse ○ Child/Dependent

Some of your procedures may be covered by your ***Medical Insurance*****.**

3 - Do you have: **MEDICAL INSURANCE?** **Yes** ____ **No**____ If yes, **Name**: _________________________

Primary Subscriber Full Name:____ DOB: ___ /___ /_____

Member ID or SSN: ______________________ Employer Name: _______________________ Group No.: _____________

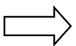
Insurance Phone Number: ___________________ Relationship To The Subscriber: ○ Self ○ Spouse ○ Child/Dependent

Cancellation Policy

MiraMar Family Dental understands that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be canceled at least 24 hours in advance. Our doctor wants to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen.
As *of June 1, 2019* there will be a fee of $25.00 assessed if we do not receive a call or text to cancel an appointment. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients!

INSURANCE PATIENTS: Filing insurance is not an exact science; as a courtesy to you, we will verify your insurance for eligibility and benefits prior to your initial visit as well as any time you notify us of a change in your coverage. We cannot guarantee that the information we receive is a guarantee of payment. Insurance companies state that coverage is only an ***estimation*** of benefits. You are ultimately responsible for knowing what your plan covers or does not cover and if there are waiting periods for work to be performed. Any amounts not covered by your plan, except for contractual fee discounts, are your financial responsibility. **I hereby authorize the assignment of benefits. _____ (initial)**

I understand that I am financially responsible for all charges not paid by insurance. MiraMar Family Dental may use my health care information and may disclose such information to my insurance company (ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits payable for related services, as pertaining to the HIPAA guidelines.



______________________________	______________________________	______________
Patient or Parent Name (Print)	Patient or Parent Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

MiraMar Family Dental
6127 N Fry Rd
Katy, TX 77449

By signing below I acknowledge that I have received and reviewed a copy of MiraMar Family Dental's *HIPAA Notice of Privacy Practices*.

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

I understand that, if I have questions about MiraMar Family Dental's *HIPAA Notice of Privacy Practices*, I may contact MiraMar Family Dental at 832-779-8444.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that MiraMar Family Dental 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 MiraMar Family Dental's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the Office Manager, noted above, for assistance.

Patient Name: ____

Patient/Responsible Party Signature: ___________________________________ Date: ____________

If you are not the patient, please fill out the following information:

Responsible Party Name: ____

Responsible Party DOB: ____

Relationship to Patient: ____

Address: ____

Telephone: ____

People allowed access to my medical records:

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________