PATIENT REGISTRATION

Full Name:_____ **Preferred Name:**_____ **Date:**_____

Date of Birth:_____ **Age:**_____ **Sex: M ___ F ___** **Social Security:**_____

Social Security — optional; needed only for patients with financing or insurance.

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **Email:**_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Language Preference: Spanish ___ English ___

Emergency Contact — Name:_____ **Phone Number:**_____

Whom may we thank for referring you to our office?

□ Friend: _____ □ Google □ Instagram □ Facebook □ Nextdoor □ TikTok □ Yelp □ Other: _____

When was your last visit to the dentist (approximately)? _____

Responsible Party (if someone other than the patient is financially responsible for treatment)

Full Name:_____ **Date of Birth:**_____

Relationship to Patient:_____

Communication Consent

By providing my phone number and selecting "YES" below, I agree to receive text messages (SMS) from MiraMar Family Dental, including appointment reminders and, if I opt in, account and promotional messages. Message frequency varies (up to about 4 per month) and message and data rates may apply. I can reply STOP to cancel or HELP for help at any time. Consent is not a condition of treatment. Mobile information is not shared with third parties or affiliates for marketing. See our Notice of Privacy Practices for details.

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 Practices and I have been provided the opportunity to review it. I understand that I may also review it at any time at miramarfamilydental.com.

Consent to Audio Recording & AI-Assisted Documentation

The practice uses a secure AI-assisted tool — from a vendor under a HIPAA Business Associate Agreement — that records audio of your visit and converts it to text to help create your clinical notes, which are reviewed and approved by your treating provider. Recordings and transcripts are part of your protected health record, are not used to train AI models, and are handled under our Notice of Privacy Practices. It is voluntary and does not affect your treatment; you may decline or withdraw at any time.

□ **I consent to audio recording for AI-assisted documentation.** □ **I decline.**

Consent for Dental Exam and X-Rays

I, the undersigned, voluntarily consent to and authorize the dental provider(s) and the 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.

Fee note: For cash patients without dental insurance, the fee for the exam and X-rays is $75. This does not include dental cleaning, consultations with specialists doctors, 3D radiographs such as CBCT scans, or 3D intraoral scans.

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 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

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 reaction 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: _____

Check any of the following that you have had or have:

□ AIDS/HIV	□ Anaphylaxis	□ Anemia	□ Angina
□ Arthritis/Gout	□ Artificial Heart Valve	□ Artificial Joint	□ Asthma
□ Blood Disease	□ Blood Transfusion	□ Breathing Problems	□ Bruise Easily
□ Cancer	□ Chemotherapy	□ Chest Pains	□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder	□ Convulsions	□ Cortisone Medicine	□ Diabetes
□ Drug Addiction	□ Easily Winded	□ Emphysema	□ Epilepsy or Seizures
□ Excessive Bleeding	□ Excessive Thirst	□ Fainting Spells/Dizziness	□ Frequent Coughs
□ Frequent Diarrhea	□ Frequent Headaches	□ Genital Herpes	□ Glaucoma
□ Hay Fever	□ Heart Attack/Failure	□ Heart Disease	□ Heart Murmur
□ Heart Surgery	□ Heart Trouble	□ Hemophilia	□ Hepatitis A/B/C
□ Herpes	□ High Blood Pressure	□ High Cholesterol	□ Hives or Rash
□ Hypoglycemia	□ Irregular Heartbeat	□ Kidney Problems	□ Leukemia
□ Liver Disease	□ Low Blood Pressure	□ Lung Disease	□ Mitral Valve Prolapse
□ Osteoporosis	□ Pain in Jaw Joints	□ Parathyroid Disease	□ Psychiatric Care
□ Radiation Treatments	□ Recent Weight Loss	□ Renal Dialysis	□ Rheumatic Fever
□ Rheumatism	□ Scarlet Fever	□ Shingles	□ Sickle Cell Disease
□ Sinus Trouble	□ Spina Bifida	□ Stomach Disease	□ Stroke
□ Swelling of Limbs	□ Thyroid Disease	□ Tonsillitis	□ Tuberculosis
□ Tumor Growths	□ Ulcers	□ Venereal Disease	□ 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 Name:_____
Primary Subscriber Full Name:_____ Date of Birth:_____
Member ID or SSN:_____ Employer Name:_____ Group No.:_____
Insurance Phone:_____ Relationship to Subscriber: □ Self □ Spouse □ Child/Dependent

2. Do you have SECONDARY DENTAL INSURANCE? ___ Yes ___ No Name:_____
Primary Subscriber Full Name:_____ Date of Birth:_____
Member ID or SSN:_____ Employer Name:_____ Group No.:_____
Insurance Phone:_____ Relationship to Subscriber: □ Self □ Spouse □ Child/Dependent

INSURANCE PATIENTS: As a courtesy, we will verify your insurance eligibility and benefits prior to your initial visit and will update your records anytime you notify us of a change to your plan. Please remember that filing dental insurance is not an exact science, and the information provided by your insurance company is only an estimate of benefits — not a guarantee of payment. Please note that our office is an out-of-network dental clinic, and we do not participate in-network with any dental insurance companies or third-party insurance agreements. You are ultimately responsible for understanding your plan's coverage, including any exclusions, waiting periods, or limitations. Any fees not covered by your insurance plan, aside from contractual discounts, are your financial responsibility. I hereby authorize the assignment of insurance benefits to this office.

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 that scheduled appointments be canceled at least 24 hours in advance for basic treatment and 48 hours in advance for major treatment. 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. **A fee of $50.00 for basic treatment and $100.00 for major treatment will be charged to your account 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. This policy allows us to open otherwise unused appointments to better serve the needs of all patients.

- To ensure that time with the doctor is reserved specifically for you, we require that all treatment fees be paid in full at least 48 hours prior to your scheduled appointment. This policy allows us to prepare properly for your visit and maintain availability for all of our patients.

- X-Ray Copies Policy: Copies of X-rays may be requested for an administrative fee of $25. Please allow up to 24 hours for processing. X-rays will be sent to the email address provided on the authorization release form. To comply with HIPAA regulations, a signed release authorization form is required before any records can be sent.

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 I may also review and obtain a copy of the Notice of Privacy Practices at any time at miramarfamilydental.com.

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 the 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 signing this Acknowledgement is voluntary and that MiraMar Family Dental will not deny me treatment if I choose not to sign.

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 Date of Birth:_____

Relationship to Patient:_____

Address:_____

Telephone:_____

People allowed access to my medical records:

Name:_____ **Date of Birth:**_____

Name:_____ **Date of Birth:**_____

Name:_____ **Date of Birth:**_____