

New Patient Registration

Date: _____

Patient Name: _____ M F Age: _____

Date of Birth: _____ Drivers License # _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____ *(A valid email is required for patient correspondence)*

Emergency Contact: _____ Relationship: _____ Phone: _____

Name & Phone Number of Preferred Pharmacy: _____

How did you hear about our office? _____

Responsible Party *(If the patient is a minor)* _____ Phone: _____

Relationship to the Patient: Parent Legal Guardian Other: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: _____

Insurance Information

Name of Policy Holder: _____ Date of Birth _____ M F

Name of Insurance: _____ ID# _____ Group # _____

Employer/Group Name: _____ Ins. Phone Number: _____

Insurance Billing Address: _____

Relationship to the Patient: Self Spouse Parent Legal Guardian Other: _____

Please fill out the rest if the insured individual is not the patient:

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell _____ SSN _____

Email Address: _____

MEDICAL AND DENTAL HISTORY

Are you currently under a physician's care? Y N If yes, please explain: _____

Have you been hospitalized or had major operation? Y N If yes, please explain: _____

Have you had serious head and neck injury? Y N If yes, please explain: _____

Are you taking any medication or pills? Y N If yes, please explain: _____

Are you on a special diet? Y N If yes, please explain: _____

Do you smoke or use tobacco? Y N If yes, please explain: _____

Do you use controlled substances? Y N If yes, please explain: _____

Women: Are you currently pregnant / trying to get pregnant? Y N

Are you currently nursing? Y N

Are you currently taking contraceptives? Y N If yes, please list _____

Are you allergic to any of the following? Aspirin Penicillin Codeine Local Anesthetics
 Acrylic Metals Latex Sulfa Other: _____

Have you ever been instructed by a physician to take a pre-medication or take any special precautions prior to dental treatment? Y N If yes, please explain: _____

Please check **Yes** or **No** for any of the following that you have or have had in the past:

AIDS/HIV	Y <input type="checkbox"/> N <input type="checkbox"/>	Fainting Spells/Dizziness	Y <input type="checkbox"/> N <input type="checkbox"/>	Osteoporosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Alzheimer's Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Frequent Cough	Y <input type="checkbox"/> N <input type="checkbox"/>	Pain in jaw joints	Y <input type="checkbox"/> N <input type="checkbox"/>
Anaphylaxis	Y <input type="checkbox"/> N <input type="checkbox"/>	Frequent Diarrhea	Y <input type="checkbox"/> N <input type="checkbox"/>	Parathyroid	Y <input type="checkbox"/> N <input type="checkbox"/>
Anemia	Y <input type="checkbox"/> N <input type="checkbox"/>	Frequent Headaches	Y <input type="checkbox"/> N <input type="checkbox"/>	Psychiatric Care	Y <input type="checkbox"/> N <input type="checkbox"/>
Angina	Y <input type="checkbox"/> N <input type="checkbox"/>	Genital Herpes	Y <input type="checkbox"/> N <input type="checkbox"/>	Radiation Treatments	Y <input type="checkbox"/> N <input type="checkbox"/>
Arthritis/Gout	Y <input type="checkbox"/> N <input type="checkbox"/>	Glaucoma	Y <input type="checkbox"/> N <input type="checkbox"/>	Recent Weight Loss	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial Heart Valve	Y <input type="checkbox"/> N <input type="checkbox"/>	Hay Fever	Y <input type="checkbox"/> N <input type="checkbox"/>	Rheumatic Fever	Y <input type="checkbox"/> N <input type="checkbox"/>
Artificial Joint	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Attack/Failure	Y <input type="checkbox"/> N <input type="checkbox"/>	Rheumatism	Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Murmur	Y <input type="checkbox"/> N <input type="checkbox"/>	Scarlet Fever	Y <input type="checkbox"/> N <input type="checkbox"/>
Blood Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Pacemaker	Y <input type="checkbox"/> N <input type="checkbox"/>	Shingles	Y <input type="checkbox"/> N <input type="checkbox"/>
Blood Transfusion	Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Trouble/Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Sickle Cell Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Breathing Problem	Y <input type="checkbox"/> N <input type="checkbox"/>	Hemophilia	Y <input type="checkbox"/> N <input type="checkbox"/>	Sinus Trouble	Y <input type="checkbox"/> N <input type="checkbox"/>
Bruise Easily	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis A	Y <input type="checkbox"/> N <input type="checkbox"/>	Spina Bifida	Y <input type="checkbox"/> N <input type="checkbox"/>
Cancer/Chemo	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis B or C	Y <input type="checkbox"/> N <input type="checkbox"/>	Stomach/Intestinal Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Chest Pains	Y <input type="checkbox"/> N <input type="checkbox"/>	Herpes	Y <input type="checkbox"/> N <input type="checkbox"/>	Stroke	Y <input type="checkbox"/> N <input type="checkbox"/>
Cold Sores/Fever Blisters	Y <input type="checkbox"/> N <input type="checkbox"/>	High Blood Pressure	Y <input type="checkbox"/> N <input type="checkbox"/>	Swelling of Limbs	Y <input type="checkbox"/> N <input type="checkbox"/>
Congenital Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	High Cholesterol	Y <input type="checkbox"/> N <input type="checkbox"/>	Thyroid Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Convulsions	Y <input type="checkbox"/> N <input type="checkbox"/>	Hives or Rash	Y <input type="checkbox"/> N <input type="checkbox"/>	Tonsillitis	Y <input type="checkbox"/> N <input type="checkbox"/>
Cortisone Medicine	Y <input type="checkbox"/> N <input type="checkbox"/>	Hypoglycemia	Y <input type="checkbox"/> N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Irregular Heartbeat	Y <input type="checkbox"/> N <input type="checkbox"/>	Tumors or Growths	Y <input type="checkbox"/> N <input type="checkbox"/>
Drug Addiction	Y <input type="checkbox"/> N <input type="checkbox"/>	Kidney Problems	Y <input type="checkbox"/> N <input type="checkbox"/>	Ulcers	Y <input type="checkbox"/> N <input type="checkbox"/>
Easily Winded	Y <input type="checkbox"/> N <input type="checkbox"/>	Leukemia	Y <input type="checkbox"/> N <input type="checkbox"/>	Venereal Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Emphysema	Y <input type="checkbox"/> N <input type="checkbox"/>	Liver Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Yellow Jaundice	Y <input type="checkbox"/> N <input type="checkbox"/>
Epilepsy or Seizures	Y <input type="checkbox"/> N <input type="checkbox"/>	Low Blood Pressure	Y <input type="checkbox"/> N <input type="checkbox"/>	Other: _____	
Excessive Bleeding	Y <input type="checkbox"/> N <input type="checkbox"/>	Lung Disease	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	
Excessive Thirst	Y <input type="checkbox"/> N <input type="checkbox"/>	Mitral Valve Prolapse	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	

Do you have or have you had any other conditions not listed above? No Yes _____

Are you nervous about dental treatment? No Yes

Have you even had an upsetting dental experience? No Yes _____

Please check and of the following that apply to you:

-Sensitivity (hot, cold, sweet) Y N -Grinding or clenching teeth Y N

-Headaches, ear aches, neck aches or jaw joint pain? Y N -Bleeding, swollen or irritated gums Y N

-Mouth ulcers or cold sores Y N -Loose, tipped or shifting teeth Y N

-Broken teeth or broken fillings Y N When was your last dental visit? _____

The questions on this form have been answered to the best of my ability. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr Miller of any changes to my health and/or medical status.

Signature: _____ Date: _____

INSURANCE AND FINANCIAL GUIDELINES
PLEASE READ THE FOLLOWING AND INITIAL EACH LINE

____ I authorize my insurance company to pay directly to the dentist (Logan B. Miller, DDS, DBA North Austin Dentistry) any and all insurance benefits for any and all services rendered.

____ I understand that despite verifications of eligibility & benefits made by this office prior to my appointment, **insurance companies never guarantee payment** for services rendered. If my insurance carrier does not pay, or pays less than my actual bill, I agree that I am responsible for payment of all services rendered on my behalf or on behalf of my dependents.

____ I understand that the full responsibility for payment of all fees for dental services provided in this office for me or my dependents is mine, due and payable at the time services are rendered, regardless of insurance coverage.

____ I understand the financial obligation attached to this procedure and agree to comply as listed on a separate service agreement, where I understand and acknowledge that I am financially responsible for all fees for the services provided for myself or the above named, regardless of insurance coverage.

____ I understand that it is imperative that I am aware of my insurance policy coverage, and it is my responsibility to inform the office should there be any changes in my policy.

____ I understand that when I schedule an appointment, the time is reserved exclusively for me and that there will be a minimum charge of \$50.00, depending on the type and length of the procedure, for any appointment failed or rescheduled without 48 hour for cleaning and 1week for treatment notice. Repeated cancellations will require a deposit for every appointment, and further delinquency may result in my dismissal from this practice.

____ I understand that a deposit may be required for some appointments depending on the length of the appointment or amount of treatment to be performed. I will be notified if my appointment requires a deposit, and I agree to comply with the terms as listed on a separate service agreement.

____ I understand that payment is expected in full at the time of my appointment. If I require financial arrangements, I will inform the front desk staff prior to my scheduled appointment. Any amount due over \$300 will be collected before the appointment begins.

____ I understand that personal checks are accepted up to \$500.00, and a card must be left on file as a backup.

____ In the event of default, I will be charged for a \$30.00 Non-Sufficient Funds Fee for insufficient funds, along with any reasonable attorney's fee and collection cost. I further understand that a monthly billing charge may be added to any balance over 30 days.

____ Credits will remain on my account unless otherwise requested. All refunds will be in the form of a check that must be picked up in person.

____ I understand that North Austin Dentistry will attempt to call , email, and text me if I have a balance. If no response after 30 day, North Austin Dentistry will automatically charge my card for any unpaid balance whether for broken appointment fees or insurance denial.

A comprehensive outline of the Financial and Insurance Billing guidelines can be found in the waiting room.
By signing below, I certify that I have read and understand the Insurance and Financial Guidelines of North Austin Dentistry.
I have asked any and all questions, and they have been answered to my satisfaction.

Patient Name: _____

Date: _____

Patient Signature: _____

GENERAL CONSENT
PLEASE READ THE FOLLOWING AND INITIAL EACH LINE

_____ I authorize North Austin Dentistry to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.

_____ *Drugs and Medication:* I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____ *Anesthesia:* I realize the risks in receiving an anesthetic, some of which are upset stomach, dizziness, and vomiting, adverse reaction to drugs causing cardiac arrest, and miscarriage.

_____ *Changes in Treatment Plan:* I understand that during the course of the procedure(s), unforeseen conditions may arise which necessitate procedures different from those originally planned. I understand that during treatment it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination. I consent to any/all changes and additional procedure(s) which Dr Miller may consider necessary.

_____ I understand that dentistry is not an exact science and that reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have requested and authorized

_____ I understand there may be a case fee associated with the cost of the treatment necessary. Case fees are charged for high-quality aesthetics and office warrantee.

_____ I understand there may be non-covered serviced that will not be billed to my insurance. North Austin Dentistry's treatment has an added-value work that is above standard CDT description & qualifies for an additional fee.

_____ I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for education purpose, security purposes and/or the practice's healthcare operations purposes.

_____ I consent to receive text messages and emails from the practice. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information. Standard text messaging rates may apply; contact your carrier for pricing plans and details.

_____ I authorize North Austin Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners, to the extent permitted under applicable law.

HIPAA ACKNOWLEDGEMENT
PLEASE READ THE FOLLOWING AND INITIAL EACH LINE

_____ **Notice of Privacy Practices:** I acknowledge that I have received the practice's Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment activities, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the Notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my protected health information for the purposes described in the practices Notice of Privacy Practices.

_____ **Release of Information:** I hereby permit North Austin Dentistry practice, other dental or medical health professionals and insurance companies involved in my dental care to release healthcare information for purposes of care decisions, treatment, payment, or healthcare operations.

_____ **Disclosures to Friends and/or Family Members:** I give permission for my protected health Information to be disclosed for purpose of communicating diagnosis, treatment and care decisions to the family members and other listed below:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the

changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, through our website www.northaustdentist.com.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____

Date: _____