AUSTIN DENTISTRY

Patient Registration

To help us meet all of your dental needs please fill out this form ***completely and accurately.***

PATIENT INFORMATION

Name:_____ Birthdate:_____ Age:_____ Male/Female

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

Home Telephone #:_____ Alt. #_____

Do we currently see any family members? Yes/No If so, their name(s)? _____

Whom may we thank for referring you to our office? _____

Email:_____

INSURANCE INFORMATION

As a **courtesy** we accept assignment of benefits from most insurance companies. In order to do so, you must provide us with the following information:

Policy Owner:_____ Relationship to patient:_____

Insured's SS#_____ Birthdate:_____ Employer:_____

Insurance Company:_____ Phone #:_____

Group name:_____ Group #:_____Address:_____

I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me.

SIGNATURE:_____

DENTAL HISTORY

Why are you here today?_____

When was your last dental visit?_____

Have there been any injuries to your teeth?_____

Please circle if you have had any of the following problems or oral habits: Cavities / Toothache / Bad Breath / Crooked teeth / Sensitive to sweets / Bleeding gums / Sensitive to hot or cold / Frequent headaches / Discolored teeth / Loose teeth / Teeth bumped / Teeth grinding /

Other:_____

_____

MEDICAL HISTORY

Patients physician:_____Phone #_____

Are you in good general health? Yes/No. If no please describe:_____

_____

Any drug or food allergies? Yes/No. If so please list and describe the type of reaction: _____

_____

Have you had any surgical operations? Yes/No. If so, please describe:_____

_____

Have you ever been hospitalized? Yes/No. If yes, please explain:_____

_____

Please circle yes or no for any of the following conditions you have had or now have:

Allergies	Y / N	Eating Disorder	Y / N	Steroid therapy	Y / N
Asthma	Y / N	Abnormal bleeding	Y / N	Chemotherapy	Y / N
Heart trouble	Y / N	Blood transfusion	Y / N	Nervous/mental disorder	Y / N
Heart Murmur	Y / N	Birth defects	Y / N	Convulsions or seizures	Y / N
Rheumatic fever	Y / N	Kidney disease	Y / N	Frequent diarrhea	Y / N
Blood disease	Y / N	Cleft lip or palate	Y / N	Mumps or measles	Y / N
Anemia	Y / N	Scarlet fever	Y / N	Chicken pox	Y / N
AIDS virus	Y / N	High fever	Y / N	Cancer/tumor/cysts	Y / N
Diabetes	Y / N	High/low Blood pressure	Y / N	Sinus problems/drainage	Y / N
Ear/eye/nose/throat problem	Y / N	Liver disease	Y / N	Tuberculosis or TB exposure	Y / N
Stomach ulcer	Y / N	Jaundice/hepatitis	Y / N	Problems with anesthesia	Y / N
Thyroid disease	Y / N	Any other condition?_____			

CURRENT MEDICATIONS

Name/strength	How often?	Reason taken?

Authorization and release: I understand that a payment of a calculated % is due at the time of treatment, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by my dental insurance company within 30 days of the date of service. I understand that any unpaid balances may be sent to a collection company and I will be responsible for all collection charges. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this dental office of any changes in my medical status. I authorize this office to release any information, including the diagnosis and records of any treatment or examination rendered to myself during the period of such dental care to third party payers' and or other health practitioners.

PATIENT SIGNATURE:_____ DATE:_____

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FINANCIAL POLICY

INSURANCE BENEFITS

I understand it is my responsibility to inform and update this office of any changes in dental insurance coverage and also update any changes in address or contact phone numbers. I understand that this office requires ***24 hours*** notice in order to verify my child's coverage. If adequate notice is not given, I am aware that it is my responsibility to reschedule my child's dental appointment or pay the full fee of the visit.

UNPAID INSURANCE BENEFITS

All dental services provided, whether the patient has dental insurance or not, are charged directly to the financially responsible party and that he or she is personally **responsible for payment of all dental services**. If the insurance company has not paid a claim after 60 days of being submitted, this office will require the patient to pay the account balance unless other arrangements have been made. **It is your responsibility to know your plan and its limitations including but not limited to your deductible, plan maximum and coverage details.**

TREATMENT ESTIMATES

Austin Dentistry routinely provides our patients with an estimate of cost for the purposed treatment. Since ***your insurance*** determines the benefit payable for services, this office can not be held responsible for 100% accuracy on what is only an estimate for treatment. This office provides ***only an estimate*** based on your insurance coverage. All insurance companies provide a disclaimer when insurance benefits are being quoted:

"Information is subject to change. Benefits described are not a guarantee of payment. Actual benefits payments are determined only when a claim is received, eligibility is not a guarantee of coverage."

COLLECTION ACCOUNTS

If an account is turned over to a collection agency and or attorney for collection, the account holder will be responsible for all attorney and collection fees. **Any account that is 90 days past due is subject to being sent to collections.** Unless other arrangements have been made.

I hereby verify with my signature below that I have read and understood the office policies stated above and also grant Austin Dentistry and/or affiliates permission to contact me in matters related to this form.

PATIENT NAME:_____

PATIENT SIGNATURE:_____

WITNESS:_____DATE:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.

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)

_____

_____

_____

AUSTIN
DENTISTRY

CONSENT FOR DENTAL PROCEDURES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

At each examination appointment, we will identify any dental treatment needed and describe this to you. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc., will be preformed at a separate appointment after obtaining your permission.

State law requires that we obtain your written informed consent for any treatment given to you.

1. I hereby, authorize and direct the doctor(s) of Austin Dentistry assisted by dental auxiliaries of his or her choice, to perform the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedures or operation may include:

   A. Cleaning of the teeth and the application of topical fluoride.

   B. Application of plastic "sealants" to the grooves of the teeth.

   C. Treatment of the diseased or injured teeth with dental restoration (fillings or caps)

   D. Replacement of missing teeth with dental prosthesis.

   E. Treatment of malposed (crooked) teeth and or oral developmental or growth abnormalities.

   F. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts form 1 1/2 to 3 hours.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize the doctors of **Austin Dentistry** to perform treatment as may be advisable to preserve my health and life.

I also understand that I have a right to be provided with answers to questions which may arise during the course of my treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

DATE:_____TIME:_____am/pm

PATIENT SIGNATURE:_____

WITNESS:_____