TIME 4:41 PM

DATE 7/25/2016

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: Policy Holder Preferred Name:
Responsible Party

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: Age: Soc. Sec: Drivers Lic:

E-mail: I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg.:

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City,State,Zip: City,State,Zip:

Rem. Benefits: .00 Rem. Deduct: .00

Medical History

Name _____

DOB _____

1 Driver's license #: _____

2 ☐ Yes ☐ No Married? If yes, spouse's name:

3 ☐ Yes ☐ No Are you taking any prescription or non-prescription medications including vitamins, herbal medications, remedies and/or recreational drugs? If so, please list _____

4 ☐ Yes ☐ No Do you take birth control medication?

5 ☐ Yes ☐ No Are you allergic to any medication, local anesthetic, materials or latex gloves?

6 ☐ Yes ☐ No Do you have diabetes? If so, type 1 ☐ or type 2 ☐

7 ☐ Yes ☐ No If yes to question 6, when was your last HbA1c done and what was the level? _____

8 ☐ Yes ☐ No Do you snore or have sleep apnea?

9 ☐ Yes ☐ No Have you had any major surgery?

10 ☐ Yes ☐ No Do you have a history of fainting?

11 ☐ Yes ☐ No Have you ever had a serious accident involving head injuries?

12 ☐ Yes ☐ No Have you had any radiation, chemotherapy or other cancer treatment?

13 ☐ Yes ☐ No Do you have any artificial joints (knee, hip, etc) ?

14 ☐ Yes ☐ No Have you ever bled excessively after being cut or injured?

15 ☐ Yes ☐ No Do you have any reason to suspect you have been in contact with the AIDS virus or have tested positive for HIV?

16 ☐ Yes ☐ No Do you use tobacco products? If so, what and how often? _____

17 ☐ Yes ☐ No Do you have well water (private)?

18 ☐ Yes ☐ No Does your drinking water contain fluoride?

19 ☐ Yes ☐ No Have you ever been treated for gum disease?

20 ☐ Yes ☐ No Do you clench or grind your teeth?

21 ☐ Yes ☐ No Do you suffer from headaches?

22 ☐ Yes ☐ No Does your jaw click or pop?

23 ☐ Yes ☐ No Have you experienced any pain or soreness in the muscles of your face or around your face or around your ear?

24 ☐ Yes ☐ No Do you have any dental implants?

25 ☐ Yes ☐ No Are you happy with your smile?

26 ☐ Yes ☐ No Would you like a whiter smile?

27 ☐ Yes ☐ No Are you interested in straightening your teeth?

28 ☐ Yes ☐ No Are you concerned with your breath?

29 ☐ Yes ☐ No Are you interested in sedation dentistry?

Do you have or have you ever had:

30 ☐ Yes ☐ No Any heart condition

31 ☐ Yes ☐ No High/Low Blood Pressure

32 ☐ Yes ☐ No Stroke or Mini Stroke

33 ☐ Yes ☐ No Pacemaker

34 ☐ Yes ☐ No Artificial/prosthetic heart valve

35 ☐ Yes ☐ No Congentinal heart disease (heart defects at birth)

36 ☐ Yes ☐ No Heart transplant

37 ☐ Yes ☐ No Bacterial Endocarditis

38 ☐ Yes ☐ No Anemia or excessive menstrual bleeding

39 ☐ Yes ☐ No Blood transfusion

40 ☐ Yes ☐ No Blood disease/Leukemia

41 ☐ Yes ☐ No Liver disease, hepatitis and or jaundice

42 ☐ Yes ☐ No Nervous disorder

43 ☐ Yes ☐ No Epilepsy

44 ☐ Yes ☐ No Ulcer or GERD

45 ☐ Yes ☐ No Cortisone-Steriod treatment

46 ☐ Yes ☐ No Breathing problems

47 ☐ Yes ☐ No Sinus problems

48 ☐ Yes ☐ No Asthma

49 ☐ Yes ☐ No Tuberculosis

50 ☐ Yes ☐ No Hay fever

51 ☐ Yes ☐ No Kidney trouble

52 ☐ Yes ☐ No Arthritis

53 ☐ Yes ☐ No Cancer or malignancy

54 ☐ Yes ☐ No Osteoporosis

Please explain any YES answers:

56 ☐ Yes ☐ No Is there a chance that you could be pregnant? If yes, delivery date.

57 ☐ Yes ☐ No Do you have any disease, condition or problem not listed or anything about your health that we have not covered?

If so, please list: _____

58 Date of your last dental visit. ____________

59 ☐ Yes ☐ No Were x-rays taken at that time?

60 ☐ Yes ☐ No Were your teeth cleaned?

61 ☐ Yes ☐ No Do you have an immediate dental problem? If so, where does it bother you and when did it start?

62 Medical doctor name & phone #:

63 Date of last physical: ____________

64 In case of an emergency, person outside of the home to contact & phone #:

RELEASE:

A. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

B. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

C. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

D. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

E. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payments in full for all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

F. I attest to the accuracy fo the information of this page. I understand that it is my responsibility to inform the Doctor and the office staff of any changes in my medical status at the very next appointment, before any further treatment is rendered to me.

____________ ____________ ____________ ____________

PATIENT'S or GUARDIAN'S SIGNATURE | Relationship to Patient | Date | Doctor's Signature Upon Completion

Medical History Update

I have accurately advised my dental care provider of my *current* health status and any dietary or herbal supplements, medications and/or drugs (including recreational and OTC) that I am taking or have taken in the last week.

SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No

Changes/Updates:____________

Present medications:____________

PATIENT'S or GUARDIAN'S SIGNATURE | Relationship to Patient | Date | Doctor's Signature Upon Completion

SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No

Changes/Updates:____________

Present medications:____________

PATIENT'S or GUARDIAN'S SIGNATURE | Relationship to Patient | Date | Doctor's Signature Upon Completion

SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No

Changes/Updates:____________

Present medications:____________

PATIENT'S or GUARDIAN'S SIGNATURE | Relationship to Patient | Date | Doctor's Signature Upon Completion

SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No

Changes/Updates:____________

Present medications:____________

PATIENT'S or GUARDIAN'S SIGNATURE | Relationship to Patient | Date | Doctor's Signature Upon Completion

SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No

Changes/Updates:____________

Present medications:____________

PATIENT'S or GUARDIAN'S SIGNATURE | Relationship to Patient | Date | Doctor's Signature Upon Completion

PORT LAVACA FAMILY DENTISTRY

621 N. VIRGINIA ST
PORT LAVACA, TX 77979
361-552-6814

Authorization to Release & Discuss Dental Information

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, and insurance providers unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included: their name must be explicitly stated below.** You may opt out by checking the "Do not Release Information" box below.

Authorization to speak with family/friends (including spouse)

I give the following named person(s) authorization to speak with the office of Port Lavaca Family Dentistry, on my half regarding **(please check all items authorized).**

Name of authorized person(s):_____Relationship_____
Phone number_____
____Appointments ____Financial ____Dental Treatment ____Insurance ____Other (explain)_____

Name of authorized person(s):_____Relationship_____
Phone number_____
____Appointments ____Financial ____Dental Treatment ____Insurance ____Other (explain)_____

Name of authorized person(s):_____Relationship_____
Phone number_____
____Appointments ____Financial ____Dental Treatment ____Insurance ____Other (explain)_____

____ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare providers should I wish to change one or more contacts listed above.

Patient's Name _____ Date of birth _____

_____ Date _____

Signature of patient or patient's authorized representative

Authorization and Consent to Send Unencrypted Patient Info By Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Port Lavaca Family Dentistry to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Port Lavaca Family Dentistry's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Port Lavaca Family Dentistry may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Port Lavaca Family Dentistry does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Port Lavaca Family Dentistry already sent before receiving my written instructions to stop.

Patient name (please print): _____

Signature: _____ Date: _____

Dental Team: Give a signed copy of this form to the patient. File original in the patient's chart.

Notice Of Privacy Practices Acknowledgement

Dr. Rhonda Nielsen
621 N. Virginia St.
(361)552-6814
Fax (361)552-8193

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restriction.

- I agree to be responsible for all charges for dental services and materials not paid by dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
- I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

PLEASE BE ADVISED THAT DR. NIELSEN IS ONLY A PARTICIPATING PROVIDER FOR UNITED CONCORDIA INSURANCE, CIGNA AND METLIFE. ALL OTHERS PLEASE NOTE THAT YOU ARE VISITING AN OUT OF NETWORK PROVIDER/DENTIST AND WILL BE RESPONSIBLE FOR THE DIFFERENCE IN BILLING.

PATIENT NAME:_____

RELATIONSHIP TO PATIENT:_____DATE_____

SIGNATURE:_____