NIELSEN FAMILY DENTAL

PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION THAT APPLIES TO YOU – THANK YOU

PATIENT INFORMATION:

LAST NAME_____FIRST NAME_____INITIAL_____

How do you wish to be addressed? _____Date of Birth: _____

□Single □Married □Divorced □Separated □Widowed □Male □Female

Social Security # ___-___-___ Driver's License # _____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____

Employer _____ Occupation _____

ID# _____ Ins. Phone Number _____

Dental Insurance Co. _____Group #_____

How did you hear about our practice? Whom may we thank for your referral? _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT):

LAST NAME_____FIRST NAME_____INITIAL_____

Address _____

City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____

Employer _____ Occupation _____

Dental Insurance Co. _____ Group #_____

ID# _____ Ins. Phone Number _____

Emergency contact name_____Phone#_____Relation_____

How would you prefer to be contacted regarding upcoming appointments? □Email □Text □Phone call

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:____

______________________ ______________________ __________ ______________________

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Present medications:____

______________________ ______________________ __________ ______________________

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Changes/Updates:____

Present medications:____

______________________ ______________________ __________ ______________________

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

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Changes/Updates:____

Present medications:____

______________________ ______________________ __________ ______________________

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

Nielsen Family Dental
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

Nielsen Family Dental

Non-Covered Services Acknowledgement Form

I, _____understand that the services performed by and/or supplies prescribed by Dr. Rhonda Nielsen may not be considered eligible for benefits by my insurance company. I understand that my insurance coverage has certain restrictions, as well as non-covered services and supplies. I understand that the **treatment plan** I am given is strictly an **estimate**.

Nearly all dental benefit plans are the result of a contract between the plan sponsor (usually an employer or a union) and the third-party payer (usually an insurance company). The amount the plan pays is determined by the agreement negotiated by the employer with the insurer. Dental coverage is determined not by the patient's dental needs, but by how much the employer contributes to the plan.

If my dependent or I choose to receive the services and/or supplies prescribed by Dr. Rhonda Nielsen and they are not covered by my insurance, I agree in advance to accept full financial responsibility for all costs associated with the non-covered services

_____ _____

PATIENT/GUARDIAN SIGNATURE PATIENT DATE OF BIRTH

_____ _____

PRINTED NAME DATE

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:_____