PATIENT REGISTRATION

Fill out form and then press the "Print Form" button.

Current Date

Home Phone

SS/HIC/Patient ID #

Cell Phone

Patient Information

Last Name First Name Initial

Address email

City State Zip Code

Male Female Age Birth date

Married Widowed Single

Separated Divorced Minor

Patient Employer/School Occupation

Employer/School Address Employer/School Phone

Whom may we thank for referring you?

In case of emergency who should be notified? Phone

Primary Insurance

Person responsible for account: Last Name First Name Initial

Relation to Patient Birth date ID#/Soc.Sec.#

Address (if different from patient) Phone Number

City State Zip Code

Person responsible employed by Occupation

Business address Business Phone

Insurance Company Contract # Group

Subscriber# Names of other dependents covered

Additional Insurance

Is the patient covered by additional insurance? Yes No

Subscriber name Relation to Patient Birth Date Soc. Sec. #

Address City State Zip Code

Subscriber employed by Business Phone

Insurance Company Contract # Group

Subscriber# Names of other dependents covered

Dental History

Reason for this visit ______ Date of last dental care ______

Former Dentist ______ Date of last dental x-rays ______

Address ______

Check the boxes below if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Grinding teeth
- ☐ Sensitivity to hot
- ☐ Bleeding gums
- ☐ Loose teeth or broken fillings
- ☐ Clicking or popping jaw
- ☐ Sensitivity to sweets
- ☐ Periodontal disease
- ☐ Food collection between teeth
- ☐ Sores or growths in your mouth
- ☐ Sensitivity to cold
- ☐ Sensitivity when biting

Medical History

Physician's name ______ Date of last visit ______

Have you had any serious illnesses or operations? ○ Yes ○ No If yes, describe ______

Have you ever had a blood transfusion? ○ Yes ○ No If yes, give approximate date ______

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand namess of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ○ Yes ○ No

(Women) Are you pregnant? ○ Yes ○ No Nursing? ○ Yes ○ No Taking birth control pills? ○ Yes ○ No

Check the boxes below if you have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are taking:

______

ALLERGIES

______

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to Dr. Daisy Moore all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______ Date ______

Signature of Patient, Parent, Guardian or Personal Representative

Please Print name of Patient, Parent, Guardian or Personal Representative ______ Relationship to Patient ______

Payment is due in full at time of treatment unless prior arrangements have been approved

OUR FINANCIAL POLICY

We are committed to provide you and your family with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

GENERAL POLICY

As a general policy, we hold patients responsible for their bills. All co-pays and uncovered procedures or amounts are payable at the conclusion of each appointment unless other financial arrangements have been made. All patients must complete our "Patient Information Form" before seeing the doctor. We reserve the right to charge a $26.00 fee for missed/cancel appointments without 24 hours notice.

INSURANCE

If you have insurance, we will help you receive your maximum benefits.
Insurance is a contract between you and your insurance company. We are mot a party to this contract in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply as much factual information as necessary.
YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

PAYMENT ARRANGEMENTS

We will attempt to approximate all charges for upcoming services. If the charges are estimated to be higher than what you could immediately handle, then you may request financial consultation. Anytime you need to discuss this, please contact this office.

Waiver of confidentiality: You understand if this account is submitted to a collection agency or attorney, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you receive treatment in our office you will be responsible for all court fees, attorney fees, and any additional fees that may occur.

Divorce: In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for those subsequent charges. If the divorce decree requires the other parent to pay all of part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: ______________________

Responsible Party Name: ______________________ Relationship to Patient: ______________________

(Parent or Guardian if Patient is a Minor)

Responsible Party Signature: ______________________ Date: ______________________

CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of Lake Cities Dental and/or dental auxiliaries of his/her choice, to perform the following dental treatment of oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.
   a. Preventative hygiene treatment, prophylaxis and the application of topical fluoride.
   b. Application of plastic "sealants" to the grooves of the teeth.
   c. Treatment of diseased or injures teeth with dental restorations (fillings and crowns).
   d. Replacement of missing teeth with dental prostheses (bridges, partial dentures, or full dentures).
   e. Removal (extraction) of one or more teeth.
   f. Treatment of diseased or injured oral tissues (hard and soft).
   g. Use of sedative drugs to control apprehension and/or disruptive behavior.
   h. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
   i. Use of general anesthesia to accomplish the necessary treatment.

2. I understand there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me. that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parents of the patients follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

4. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and will being, in the professional judgment of the dentist.

5. There are possible risks and complications associated with the administration if local anesthesia, sedation, and drugs, The most common of these are swelling, bleeding, pain, vomiting, bruising, tingling, and numbness of the lips, gum, face, tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

6. I agree to the use of local aneshesia and the use of nitrous oxide analgesia depending on the judgment of ht3e dentist(s). Nitrous oxide may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure, I understand and have been informed of the above risk and complications.

7. I hereby state that I have read and understand this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to provided answers to questions which may arise during and after the course of my treatment.

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

9. I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give permission for such items to used for purposes of research, education, publication in professional journals or in our web site.

Patient's Name:

Responsible Party Name:

(Parent or Guardian if Patient is a Minor)

Relationship to Patient:

Date:

Responsible Party Signature:

Lake Cities Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________________ E-mail: ______________________

Patient Number: ______________________ Social Security Number: ______________________

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 of our Notice, at any time by contacting:

Contact Person: Leesa______________________

Telephone: 817-410-7373______________________ Fax: 817-410-7373______________

E-mail: Leesa@LakeCitiesDental.com______________________

Address: 1101 E State Highway 114 Suite 104 Southlake, TX 76092______________

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.

SIGNATURE

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 heath care operations.

Signature: ______________________________ Date: ______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: _____