



Registration Form - Preston Bend Dental – 972-618-1111

Date: _____, 2019 Specific Referral Source: _____

PATIENT INFORMATION:

First Name: _____ Last Name: _____ Preferred: _____

SS#: _____ DOB: ____/____/____ Sex: Male or Female

Home Address: _____

GMAIL Address: _____ Other email address: _____

Cell #: _____ Work #: _____ Other #: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

DENTAL INSURANCE POLICY HOLDER INFORMATION:

Name: _____ Social Sec. #: _____ DOB: ____/____/____

Employer: _____ Insurance Company Name: _____

Insurance Company Number: _____ Insurance Company Policy Number: _____

ADMINISTRATIVE POLICY:

- 1. To provide true personalized dental care, we are NOT a network provider with any insurance policy. That means we do not sign contracts with insurance companies to treat you according to their policy limits. Only you, the patient, in consultation with a doctor will decide what dental services are rendered.
2. Insurance Policies are a contract between you and the insurance company. The final responsibility for payment rests with you, the consumer. As a courtesy, we file all insurance claims at no charge on behalf of our patients.
3. Payment for services is due when services are rendered. There will be a \$30 service fee for all returned checks.
4. If after 60 days from the date of service a balance has not been paid, the PATIENT IS RESPONSIBLE FOR THE FULL BALANCE or collection efforts may commence.
5. Please give at least one full business day notice for an appointment cancellation. There will be a \$100 charge for cancellations with less than one full business day.
6. The parent or guardian who brings the child in for their visit is responsible for payment, irrespective of what a divorce decree may state.
7. Before commencing any substantial treatment, you will be provided a written treatment plan with all the recommended treatment and associated fees.
8. It is your responsibility to inform us of any changes in your medical status, medications, insurance or contact information.

By signing below, I acknowledge that I have read, understand and accept the above Administrative Policy. I authorize the doctor and staff to release any information concerning my case to my insurance company if applicable. I authorize the doctor and staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Print Patient Name: _____

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____ Date: _____/_____/_____
 Physician's Name: _____ Phone #: _____
 Date of Last Physician Visit: _____ Pharmacy and number: _____

Please check if you have experienced **ANY** of the following (please mark **ALL** responses)

Abnormal Bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ulcer (Oral or Internal)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
AIDS (HIV+)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Kidney/Bladder Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Thyroid Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Take Aspirin/Blood Thinner	<input type="checkbox"/> YES	<input type="checkbox"/> NO	osteoporosis/osteopenia		
Artificial Heart Valves	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(i.e. taking bisphosphonates)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Alcohol/Drug Abuse	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tobacco/Cigars/E-cig	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Psychiatric Care	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Mitral Valve Prolapse	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Artificial Joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pace Maker	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Back Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cortisone/Steroid Treatment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IMPORTANT: Breathing or sleep problems?		
Tuberculosis/emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(i.e. sleep apnea, snoring, sinus)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Dry Mouth?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Body Weight: _____ lbs		
Chemotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Women Only:		
Undergone Cancer Treatment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Currently on Birth Control Pills	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis/Liver Disease (A B C D)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Currently Nursing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Herpes/Fever Blisters	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Currently Pregnant	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

Are you **ALLERGIC** to any medication, anesthetic, or materials such as zippers, costume jewelry, latex gloves, etc.?
 YES NO If yes, please explain: _____

Do you have any disease or condition, hospitalization, surgery, or anything about your health that that we may need to know?
 YES NO If yes, please explain: _____

Please list all medications, supplements, and vitamins taken within last two years.

Drug	Purpose	Drug	Purpose
1 _____	_____	5 _____	_____
2 _____	_____	6 _____	_____
3 _____	_____	7 _____	_____
4 _____	_____	8 _____	_____

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____
6. Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma? _____

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _____
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____

Authorization for Use or Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give a copy of the office notice of privacy practices and make a good faith effort to obtain an acknowledgement of receipt of same. By signing below, I confirm that I have read/received a copy of the notice of privacy practices. You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims; therefore, payment in full is due on the day of services rendered.

By signing this form, I authorize Preston Bend Dental to use and disclose my Protected Health Information described below to:

Share my Protected Health Information with (Please initial applicable authorization):

- No One
- My spouse: Name: _____ Phone Number: _____
- My mother/father/child (ren)/guardian (Cross out those not applicable.) Names: _____
- The following person(s) _____

Disclose my protected health information for the following reasons (Please initial those applicable):

- To leave an appointment reminder on my: Cell phone Work phone Home phone
- Other: _____

I understand that I have the right to revoke this authorization at any time by notifying the following:

HIPAA Administrator, Preston Bend Dental - 7600 San Jacinto Pl, Ste 100 Plano, TX 75024

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the law or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I have the right to decline signing the authorization to disclose my protected health information. This will not in any way effect my treatment.

I have the right to review the Protected Health Information to be used or disclosed or to refuse to sign this authorization. Preston Bend Dental reserves the right to receive compensation dependent on the circumstances of disclosure.

I am personally responsible to inform Preston Bend Dental, should there be any changes to any of the above.

Signature of Patient or Personal Rep. If Minor

Print Name of Patient

Date

Description of Personal Rep.'s Authority If Minor

Office use: _____ Emergency situation prevented obtaining signature