PBD

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

Date: _____ _____, 2022 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 Dr Madhav 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. We will file your insurance free of charge and have the check sent to you. **We therefore require full payment at the time of service**. For large treatment plans we can make predefined payment arrangements.
3. There will be a $30 service fee for all returned checks.
4. There will be a $100 charge for cancellations with less than 48 hours' notice.
5. The parent or guardian who brings the child in for their visit is responsible for payment, irrespective of what a divorce decree may state.
6. Before commencing any substantial treatment, you will be provided a written treatment plan with all the recommended treatment and associated fees.
7. 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 Dr Madhav and staff to release any information concerning my case to my insurance company if applicable. I authorize Dr Madhav 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	☐ YES	☐ NO	Ulcer (Oral or Internal)	☐ YES	☐ NO
AIDS (HIV+)	☐ YES	☐ NO	Kidney/Bladder Disease	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO	Thyroid Problems	☐ YES	☐ NO
Take Aspirin/Blood Thinner	☐ YES	☐ NO	osteoporosis/osteopenia		
Artificial Heart Valves	☐ YES	☐ NO	(i.e. taking bisphosphonates)	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO	Alcohol/Drug Abuse	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO	Tobacco/Cigars/E-cig	☐ YES	☐ NO
Chest Pains	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO
Mitral Valve Prolapse	☐ YES	☐ NO	Artificial Joints	☐ YES	☐ NO
Pace Maker	☐ YES	☐ NO	Back Problems	☐ YES	☐ NO
Stroke	☐ YES	☐ NO	Cortisone/Steroid Treatment	☐ YES	☐ NO
Allergies	☐ YES	☐ NO	Headaches	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	**IMPORTANT**: Breathing or sleep problems?		
Tuberculosis/emphysema	☐ YES	☐ NO	(i.e. sleep apnea, snoring, sinus)	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO	Dry Mouth?	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	**Body Weight: _____ lbs**		
Chemotherapy	☐ YES	☐ NO	***Women Only:***		
Undergone Cancer Treatment	☐ YES	☐ NO	Currently on Birth Control Pills	☐ YES	☐ NO
Hepatitis/Liver Disease (A B C D)	☐ YES	☐ NO	Currently Nursing	☐ YES	☐ NO
Herpes/Fever Blisters	☐ YES	☐ NO	Currently Pregnant	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO			
Epilepsy	☐ YES	☐ 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: _____

Dr Madhav 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.

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 or info@prestonbenddental.com

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