REGISTRATION FORM

NAME (LAST, FIRST, MIDDLE INITIAL) PREFERRED NAME

/ / M / F

DOB SEX SS#

HOME ADDRESS CITY STATE ZIP

NAME OF EMPLOYER OCCUPATION

HOME # WORK # CELL # E-MAIL:

In case of an emergency call: (close relative) HOME ADDRESS HOME PHONE #

BUSINESS ADDRESS BUSINESS PHONE #

INSURANCE INFORMATION

_____If coverage is provided by another family member:_____

DENTAL INSURANCE COMPANY NAME (LAST, FIRST, MIDDLE)

RELATIONSHIP OF RESPONSIBLE PARTY TO YOU:

RESPONSIBLE PARTY'S EMPLOYER:

CHOSE OFFICE BECAUSE /REFERRED TO OFFICE BY (PLEASE CHECK ALL THAT APPLY):

___Billboard ___Community Impact ___Location (Close to Home/Work) ___Convenient Evening/Saturday Hours

___Internet ___Money Mailer ___Val Pak ___Hays Free Press ____Kyle/Buda Eagle

___Current Patient (Please Provide Patient's Name): _____

PATIENT SIGNATURE_____DATE_____

DENTAL HEALTH AND APPEARANCE

ARE YOU PREGNANT? YES/NO IF YES, WHEN IS THE EXPECTED DELIVERY DATE?_____
DO YOU USE TOBACCO? YES/NO IF YES, HOW MUCH?_____
HAVE YOU EVER BEEN TOLD TO PRE-MEDICATE FOR DENTAL WORK? YES/NO
HAVE YOU EVER TAKEN ORAL BISPHOSPHONATES? YES/NO
ARE YOU ALLERGIC TO ANY MEDICATION(S)? YES/NO
IF YES, WHICH MEDICATION(S)?_____
ARE YOU TAKING ANY MEDICATION NOW? YES/NO
IF YES, PLEASE LIST CURRENT MEDICATION(S):

_____
_____

REASON FOR VISIT?_____ DATE OF LAST DENTAL VISIT? _____

HAVE YOU EVER HAD ANY SERIOUS PROBLEM(S) ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES/NO

IF YES, PLEASE EXPLAIN:

_____
_____

PLEASE CHECK ANY OF THE CONDITIONS YOU HAVE HAD OR CURRENTLY HAVE:

	Heart failure		Heart Disease or Attack		Angina Pectoris
	Tuberculosis (TB)		Asthma		Artificial Heart Valve
	Pacemaker		Anemia		Artificial Joint
	Stroke		Kidney Trouble		Liver Disease
	Diabetes		Cancer		Cortisone Medication
	Hepatitis		HIV positive (AIDS)		Glaucoma
	High Blood Pressure		Pain in Jaw Joints		Bruise Easily
	Drug Addiction		Hemophilia		Epilepsy or Seizures

IF YOU ANSWERED YES TO ANY OF THE PREVIOUS CONDITIONS, PLEASE EXPLAIN:

_____
_____

PLEASE LIST ANY PREVIOUS
SURGERIES:_____
_____

Patient Initials:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 also understand you are not required to agree to my requested restrictions.

Patient's Name or Patient Representative: _____(Printed)

_____ (Signature) on _____(Date)