DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient _____

Address_____

_____
City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer_____

Employer Address_____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Cell _____

E-Mail _____ Best time to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship_____

Home Phone _____ Work/Cell Phone _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State_____

Date of last dental visit _____

Date of last dental X-rays _____

Check "Yes" or "No" where indicated for all that apply:

Would you like whiter teeth?	❑ Yes	❑ No
Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw Pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken filings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in mouth	❑ Yes	❑ No

How often to you floss?_____

How often do you brush?_____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Alzheimers	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Radiation Treatment	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No	Respiratory Disease	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Hepatitis (Type _____)	❑ Yes ❑ No	Skin Rash	❑ Yes ❑ No
Bleeding abnormally, with extraction or surgery	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Special Diet	❑ Yes ❑ No
		High Blood Pressure	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	HIV Positive	❑ Yes ❑ No	Swelling of Feet or Ankles	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No	Swollen Neck Glands	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Tumor or growth on head or neck	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No		
Cough, persistent or bloody	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No	Ulcer	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No

WOMEN: Are you: **Pregnant?** ❑ Yes, _____ Months ❑ No **Nursing?** ❑ Yes ❑ No **Taking birth control pills?** ❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin ❑ Penicillin

❑ Barbiturates (Sleeping pills) ❑ Sulfa

❑ Codeine ❑ Other _____

❑ Iodine _____

❑ Latex _____

❑ Local Anesthetic _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ❑ Yes ❑ No

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

2741 Belt Line Rd #101
Carrollton, Texas 75006
(972)820-7294

Dental Treatment Consent Form

Patient Name:

1. Health Information

I agree to disclose all previous illnesses and my medical history. Undisclosed medical information, current medications, allergies, and any illnesses may be considered risk factors.

2. Drugs, Latex and medicines

I understand that antibiotics and other medicines may cause allergic reactions and even life threatening anaphylactic shock. Also, some antibiotics may interfere with birth control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat and, depending on my health, may be dangerous to me.

3. Needle Stick

If someone is inadvertently stuck with a needle or sharp instrument used on me, I consent to have blood drawn for analysis at no expense to me.

4. Fillings, Crowns and Un-anticipated Root Canals

Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth may end up needing a root canal after the filling or crown is done.

5. Root canals can fail

Root canals may fail and may require additional treatment or I may end up having the tooth extracted.

6. Porcelain Crowns, Veneers, Bonding, and Cosmetic Fillings

Porcelain crowns, veneers, cosmetic bonding and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed.

7. Extractions and Surgery

I understand that all dental extractions or surgeries carry risks. Some are minor like a dry-socket following an extraction and some are life threatening such as post-surgical infections or anaphylaxis.

8. Fee for additional or Specialty Care

I understand that I may need treatment beyond what was originally planned or I may be referred to a specialist for additional care. I agree to be financially responsible for any additional or specialty care.

9. Limitation of Insurance Coverage

There may be charges beyond what insurance will pay, e.g. nitrous oxide, temporary dentures, tapping off crowns or bridges, whitening, temporary fillings or cosmetic work. As a service to our patients, this office will file insurance claims on their behalf. I understand my payment-portion is **only an estimate.** I agree to be financially responsible for what insurance does not cover.

10. 24-Hours Notice for Cancellation

I agree to give a 24-hour notice for any cancellation or a $25.00 cancellation fee will be applied for each missed scheduled appointment.

I do not expect guarantees in dental care, I have read the above and consent to treatment.

Signature of Patient or
Parent/Guardian of Minor _____Date_____/_____/20____

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Important notice to patients taking medications for the treatment of:
Osteoporosis
Osteopenia
Bone Cancer
Post-menopausal bone loss

If you are currently taking or have been previously treated with **Fossamax (Alendronate)**, **Aredia (Pamidronate)**, **Actonel (Risodronate)**, or **Zometa (Zoledromate)** you should know there may be a risk of future complications with surgical dental treatment. This is especially true if you have received these drugs intravenously.
Please indicate if you have been prescribed any of the following medications:

	Yes	No
Fossamax	( )	( )
Aredia	( )	( )
Actonel	( )	( )
Zometa	( )	( )

These four drugs, which are taken in pill form, are associated with the problem of poor bone healing. This reduction in bone healing can occur after dental treatments that affect the bone surrounding your teeth, such as: tooth extraction, periodontal infection, or dental implant placement. If the bone surrounding your teeth does not heal properly, it could result in osteonecrosis of the jaw. Osteonecrosis means "death of the bone." This is a destructive process in the jawbone that is often difficult or impossible to eliminate.

If you have ever taken one of these drugs, maintaining your oral health is even more important. Speak to your general dentist and boost your hygiene visits to three or four times per year. Make sure you get at least one dental check-up per year from your general dentist. These extra actions will help prevent complications and preserve your jawbone.

Signature

I certify that I speak, read and write English and have read and fully understand the above notice and have had my questions answered.

_____
Patient's (Or Legal Guardian's) Signature Date

_____
Witness Signature Date

2741 Belt Line Rd #101
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PAYMENT POLICY
(INSURANCE)

We do not render our services based on what insurance companies will or will not cover. We perform our services based on our patients' oral health and the best way to maintain and/or restore their oral health.

The portion that is charged to our patients is an **estimated** amount due based on what their insurance company has conveyed to our office staff over the telephone/internet. However, if the insurance company does not cover all the fees, the patients are responsible for any and all remaining balances.

We will file insurance claims as a courtesy; however, the patients are responsible for all the fees incurred. It is also the patients' responsibility to let our office staff know about any changes in their insurance policy since their last visit to our office.

All x-rays and records belong to Epic Family Dental. Copies will be furnished to patients upon their request at a charge of $50.00 per set. Due to the nature of copied x- rays, however, their diagnostic quality cannot be guaranteed.

Patient Name: _____

Signature: _____
(Parent of Guardian if patient is a minor)

Today's Date: _____

2741 Belt Line Rd #101
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Patient's Name}

_____
{Patient's Signature}

_____
{Please Print Parent or Guardian's Name}

_____
{Parent or Guardian's Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)_____ __

Notice of Privacy Practices

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Epic Family Dental

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Afsaneh, Office Manager

Telephone: (972)820-7294

Address: 2741 Belt Line Rd #101, Carrollton, Texas 75006