PATIENT REGISTRATION

Today's Date_____ Sex: M F

Patient's Name _____ Birthdate _____
Home Address:_____ City:_____ State:____ Zip:_____
Home Phone Number_____ Work Phone_____ Cell Phone _____
Your Soc Sec. #_____ Your Employer:_____
Are you a full time student? _Yes _ No *If patient is minor we need: Mother's Birthdate:* _____ *Father's Birth Date*_____
Name of spouse (Parent if minor)_____ E-mail address _____
Spouse's (parent's) employer_____ Spouse's Soc. Sec. #_____
Spouse's Work phone _____.
How did you hear about our office? _____.
Reason for this visit_____.

EMERGENCY INFORMATION
Name, Address, & telephone of _____
A Relative Not living with you._____

DENTAL INSURANCE INFORMATION (Primary Carrier)
Insured's name _____ DOB_____ SS#_____
Insurance Co_____ Insured's employer_____
Phone #_____ Group # _____ Local #_____

If you have a double digit insurance coverage, complete this for the second coverage
Insured's name _____ DOB_____ SS#_____
Insurance Co_____ Insured's employer_____
Phone #_____ Group # _____ Local #_____

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.
Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.
Please check if you would like more information about financing options. ☐
Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred up to 35%.

Do You Have Insurance?

_ As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
_ All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
_ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
_ We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
_ We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover at the time we provide the service to you.
_ Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
_ We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

CONSENT:
The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

PATIENT Signature (Parent of Child)_____ Date_____

DENTAL HISTORY

Please check any of the following problems that apply to you.				**If you could whiten your teeth for a cost anyone could afford, would you do it?**	☐	
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐			**Do you smoke or use chewing tobacco?** How much? For how long?	☐	
-Headaches, earaches, neck pain	☐			**If I could change my smile, I would:**	☐	
-Jaw joint pain	☐			-Make them whiter	☐	
-Teeth or fillings breaking	☐			-Make them straighter	☐	
-Grinding or clenching teeth	☐			-Close spaces	☐	
-Bleeding, swollen or irritated gums -Loose, tipped or shifting teeth	☐ ☐			-Replace black metal fillings with tooth colored restorations	☐	
-Bad breath	☐			-Repair chipped teeth	☐	
Do you have or have you had any of the following?				-Replace missing teeth -Replace old crowns that don't match	☐ ☐	
-Dentures	☐			-Have a smile makeover	☐	
-Partial dentures	☐			**On a scale of 1 – 10, with 10 being the highest rating:**		
-Braces	☐					
-Periodontal (gum) treatments	☐			-How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10		
Please share the following dates: -Your last cleaning -Your last oral cancer screening -Your last complete X-Rays	___/___ ___/___ ___/___			-Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10 -Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10		

Name of Previous Dentist _____

City _____ **State** _____

Phone Number _____

Why did you leave your previous dentist?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Allergies (Seasonal)	☐ Emphysema	☐ Jaundice	☐ Rheumatism
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Scarlet Fever
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Seizures
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Stroke
☐ Asthma	☐ Heart Lesions (Congenital)	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Blood Disease	☐ Heart Murmur	☐ Nervousness/Depression	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Phen Fen (1 month +)	☐ Venereal Diseases
☐ Chemotherapy	☐ Hepatitis B	☐ Pregnant Currently	☐ Other
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	

Do you have any of the following drug allergies?

☐ Aspirin	☐ Codeine
☐ Darvon	☐ Erythromycin
☐ Nitrous Oxide	☐ Valium
☐ Percodan	☐ Penicillin
☐ Local Anesthetic	☐ Sulfa
☐ Tetracycline	☐ Other

Are you under a physician's care? What for?

_____

Are you taking any medications? What?

_____

Family Physician **Phone Number**

_____ _____

Patient Signature (Parent of Child)		Date		Dentist Signature	

Social Security Refusal

We at Manor Dental Associates understand the growing need to protect your identity from theft. We can assure you that your personal information is safe with us. We do still find that we need social security numbers from patients in order to better serve them. If in light of this information you would like to withhold your social security number that is okay. Unlike many other offices we still want you as a patient! There are just a few changes that must be made in order to serve you.

1. We will need you to pay in full at time of service for all services performed; your insurance company will have to reimburse you after treatment. This does not mean that you will be paying more for our services; you will still get your full insurance benefit, usually within 30 days.
2. Services would also need to be paid for with a either a credit card, or cash.
3. In many instances we will be unable to verify your insurance benefits. This means that we will be unable to give you accurate information on how much a procedure will cost you after insurance has made reimbursement.
4. We will need a copy of your Driver's License

Again we are happy to serve you as a patient. If you would like to withhold your social security number please sign below:

Patient Signature _____ Date _____

Print Name _____

Witness _____

MANOR DENTAL ASSOCIATES, PLLC
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MANOR TX 78653
512-278-8700
manordental@gmail.com

NOTICE OF PRIVACY PRACTICES

Purpose: This notice of Privacy Practices 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 4/14/03 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 you 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 you health or safety or the health or safety of others

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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME: _____ **BIRTHDAY**_____

SIGNATURE_____

DATE _____