Castroville Dental Phone: (830) 355-0007

PATIENT REGISTRATION

Patient is : □ ***Responsible Party*** □ ***Policy Holder***

Patient Information:

First Name: _____ Last Name:_____ Middle Initial:____

Address: _____City, State, Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Birth date: _____ Social Security #: _____ DL:_____

Email address: _____ Sex: ○ Female ○ Male

Guardian's Name if Child: _____

D.O.B_____

Policy Holder Information

Relationship to Insured: ○Self ○Spouse ○Child ○ Other

Name of Insured: _____ Member ID: _____

Insured Social Security #: _____ Insured Birth date: _____

Employer Name :_____ Employer Address:_____

Insurance Company: _____

Emp. Phone Number: _____ Ins. Phone Number: _____

Medicaid/CHIP Information:

Plan Name: _____ Member ID: _____

Physician Name: _____ Phone Number: _____

How Did You Hear About Us?

☐ Google / Search Engine ☐ Facebook ☐ Direct Flyer

☐ Newspaper ☐ Billboard ☐Community / School Event

☐ Radio ☐ Doctor Friends / Family

☐ Drive By

Medical History

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

_____

_____

Comments: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Financial Policy Consent Form

You need to be aware that:

1. Your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
2. Your treatment plan is individually tailored and is not based on your dental insurance benefits or lack of benefits.
3. We will give you an estimated treatment plan prior to the appointment. We do not know all the limitations and downgrades that each plan may have. However, parents must understand: We are only estimating insurance benefits; you are responsible for payment of any amounts the insurance does not cover, for whatever the reason.
4. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. **It is your responsibility to thoroughly understand the coverage and exceptions of your policy.**
6. As a courtesy to all our insured patients, we will file your dental insurance claim forms. In special circumstances, an insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion.
7. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately, and benefits are expected are to be paid within 30-45 days. The filling of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any other amounts your insurance company chooses not to pay for whatever reason.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.

I _____ hereby authorize my insurance benefits to be paid directly to **Castroville Dental**. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether paid by said insurance, and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient/Legal Guardian Signature: _____ Date: _____

Staff Initial: _____

Appointment Policy

A cancellation fee of $15.00 will be issued for any failed appointments without a 24-hour notice.

MEDICAID

MCNA DENTAL & DENTAQUEST are notified through our automated system if you cancel or no show for your appointment. In order to keep your insurance active, you must follow your insurance company's policy.

Patient/Legal Guardian Signature:_____ Date:_____

If you may have any questions or concerns, please feel free to contact our business manager.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Name:_____

DOB:

Patient Name (Please Print)

_____

Patient Signature Date:_____

OR

Signature of Personal Representative_____

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other:

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___A communication barrier prevented us from obtaining acknowledgement.

___The individual was unwilling to sign.

Other:_____

_____ _____

Staff Member Signature Date

Informed Consent for Dental Treatment

Patient Name: _____ Date of Birth _____

X-rays:

Proposed treatment: the taking of intraoral (inside the mouth) and extraoral (outside the mouth) radiographs.

Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development, and eruption of teeth. They are also necessary for proper diagnosis and evaluation purposes.

Alternatives to treatment: none; limited visual examination.

Common Risks: minimal radiation exposure to soft and hard tissues of the head.

I have read and understood the entire information on this consent form, which includes x-rays, All my questions were answered to my full understanding and satisfaction.t

_____ _____

Patient/ Parent / Guardian Printed Name Relationship to Patient

_____ _____

Patient/ Parent/ Guardian Signature Date

_____ _____

Witness Printed Name Witness Signature