

**PATIENT REGISTRATION**

ID: 8666 Chart ID: Last Name: Middle Initial:

First Name: Preferred Name: Patient Is:  Policy Holder  Responsible Party

Responsible Party (if someone other than the patient) Last Name: Middle Initial:

Address: Address 2: City, State, Zip: Payer: Home Phone: Work Phone: Ext: Cellular: Birth Date: Soc Sec: Drivers Lic:

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

**Patient Information**

Address: Address 2: City: Lake Jackson State / Zip: TX 77566 Payer: Home Phone: Work Phone: Ext: Cellular:

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed Birth Date: Age: Soc. Sec: Drivers Lic: E-mail:  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired

Additional Comments:

**Section 3**

Student Status:  Full Time  Part Time Medicaid ID: Pref. Dentist: Corby Gotcher, D.D.S. Employer ID: Pref. Pharmacy: Carrier ID: Pref. Hyg.: Aubrey Trahan

**Primary Insurance Information**

Name of Insured: Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company: Address: Address 2: City, State, Zip: Rem. Benefits: .00 Rem. Deduct: .00

**Secondary Insurance Information**

Name of Insured: Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company: Address: Address 2: City, State, Zip: Rem. Benefits: .00 Rem. Deduct: .00

**MEDICAL HISTORY**

FOR  
8666--.  
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

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

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  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs

Other If yes, please explain: \_\_\_\_\_

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

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

Have you ever had any serious illness not listed above?  Yes  No

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 \_\_\_\_\_

## NOTICE OF PRIVACY POLICY

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of insurance coverage.

### OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. These include but are not limited to the following:

**Treatment:** We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care provider and our staff. Our staff includes full and part time employees, as well as, temporary personnel.

**Payment:** We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies, and third party administrators such as medical reimbursement accounts.

**Operations:** We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training, certification and accreditation activities.

**Miscellaneous Uses:** At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (card, voice messages and letter), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operation or payment) and in some cases to law enforcement and court ordered releases.

### YOUR RIGHTS

**Restrictions:** You have the right to restrict or request restrictions of disclosure usage. We are not required to accept these restrictions. We will make a note of the request and honor that request if applicable.

**Access:** You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Texas State Board of Dental Examiners.

**Disclosures:** You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operation. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

**Complaints:** Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy, you should submit a written complaint to U.S. Department of Health and Human Services. We can provide you with the address upon request.

# Acknowledgement of Receipt Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, operations and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

-----

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it is not obtained.

Reason why acknowledgment was not obtained:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Comprehensive Dentistry for All Ages

At Comprehensive Dentistry we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know.....

Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefits plans will never pay for the completion of your dental care. It is only meant to assist you.

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Comprehensive Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Comprehensive Dentistry does require payment in full for your portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, who offers an eighteen month interest free payment plan approved upon patients credit history. Just ask one of the staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment we require at least 24 hour notice to avoid a \$40 per hour cancellation fee.

After Hours/Weekend Emergencies: In the event of an emergency after regular business hours a \$55 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged \$125 after hours emergency fee.

Confirmation Policy: Our office does give confirmation calls. We must have **verbal confirmation** by 1:00 pm on the date prior to your appointment in order to hold your scheduled time. Failure to confirm with a member of our staff will result in appointment cancellation.

Initial Hygiene Appointment: For all new patients a Full Mouth Series of x-rays is taken to properly diagnose any current decay. After the initial FMS, bitewing x-rays are taken at your scheduled a year at your cleanings depending on the frequency limitations set by your insurance.

Fluoride Policy: For all patients under the age of 18 we apply topical fluoride **twice** a year at each cleaning for preventive purposes. If your insurance company only pays for one application per year you will be responsible for the fee upon denial.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print: \_\_\_\_\_

Sign: \_\_\_\_\_