North Richland Hills
DENTISTRY
Cosmetic • Implant • Family

Patient Registration

Patient Name_____ Date of Birth_____ Age_____

If child, Parent's name: Mr. Mrs. Ms. Dr. _____

I prefer to be called _____Single___Married__Divorced__Widowed___ M__F__

Address _____ City _____ St_____ Zip. ____

Home Phone(_____) _____Cell Phone(_____) _____

Email Address _____

Emergency Contact Name _____ Phone Number(___) _____

Social Security Number _____ Drivers Lic # _____

Spouse Name _____

How did you hear about our office? _____

PATIENTS WITH DENTAL INSURANCE
ALL THIS INFORMATION IS NECESSARY TO VERIFY YOUR DENTAL COVERAGE!!

Name of Insured _____ Insured SS# _____

Address of Insured _____ Insured Date of Birth _____

Employer _____

Dental Insurance Company Name _____

ID/Policy Number _____ Insurance Co. Phone(___) _____

Relationship to Insured person: Self _____ Spouse _____ Child _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent have insurance coverage and assign directly to Sonal Desai, DDS 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship to Insured: Self _____ Spouse_____ Child_____

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Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician Name: _____ Physician Phone: (_____)_____

Are you currently under the care of a physician? ☐ Yes ☐ No Date of Last Visit: _____

Please explain: _____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Do you use tobacco in any form? ☐ Yes ☐ No

Have you had any metal rods, pins, or implants placed? ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No ☐ Vitamins or herbal supplements?

Please list each one: _____

Have you ever taken Bisphosphonates? (Fosamax, Boniva, Zometa) ☐ Yes ☐ No

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Bruising Easily
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Chronic Dry Mouth
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Depression
☐	☐	Dental Anxiety
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	Hearing Impairment
☐	☐	HIV + AIDS

Yes	No	Conditions
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Other Medical/Dental History
☐	☐	Pace Maker
☐	☐	Parkinson's Disease
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Therapy
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Tuberculosis (TB)
☐	☐	Ulcers

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Dental History

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Are you under stress (new job, moving, relationships)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: brush/week _____ floss/week _____

Are your teeth sensitive to heat, cold or anything else? ☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Have you ever had a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit? _____

Here at North Richland Hills Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Bonding	Implant Crowns	Smile Makeover
Crown and Bridge	Invisalign Clear Braces	Teeth Whitening
Extractions	Night Guards	TMJ Splints
Gum Therapy	Partials & Dentures	Veneers

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a ***Notice* of *Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

This is my written permission that the following people have access to my healthcare information:

_____

_____

_____

Signature of Patient or Legal Representative Witness:

Patient Signature: _____ Date: _____

Parent or Guardian Signature if Minor Patient: _____

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Practice Policy

We are honored that you have chosen us to provide your dental care. We are here to serve your dental needs and below are some general guidelines for our office:

General:

- Office hours are Monday through Thursday 7:30 am - 4:00 pm and we are closed for lunch from 12:30-1 :00. We have Oral surgery dates on select Fridays of each month and these are by appointment only.
- We do ask for notification of any appointment changes to be made directly with a staff member 24 hours prior to the scheduled appointment time. We do not accept changes on our voicemail, text or email systems.
- As a courtesy to you, all appointments will receive a call 2 days prior to the scheduled time. We do ask that you make any changes to your contact information or insurance at this time to help us better expedite your appointment.

Pavments:

- We accepts most major credit cards including American Express, Mastercard, Visa and Discover.
- For your convenience, our office also offers flexible monthly payment plans. There are also interest free plans available for up to 12 months.
- Payments for services are to be paid at the time that the services are rendered. Insurance is filed as a courtesy for our patients and balances are the responsibility of the insured.

Insurance:

- **To better assist you, we require all insurance information and verification 48 hours prior to your appointment time.**
- **Full payment at the time of service will be required when less than 48 hours notice to insurance changes are not completed. We will file insurance for this appointment to have you directly reimbursed.**

Patient Signature: _____ Date: _____

Parent or Guardian Signature if Minor Patient: _____

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No Show and Cancellation Policy

• We require 24 business hours for any appointment changes.

• Cancellations within 24 business hours of your appointment will be charge a fee of$75 per hour of appointment time. Please note that we are aware that emergencies do arise and we are willing to work with you if such circumstances occur.

• "No Show" appointments will be treated the same as a same day cancellation and therefore are subject to the $75 per hour fee.

Our office will make every effort to contact you regarding your pre-scheduled time so that we can work together to avoid any charges to your account. Please be sure to provide 2 contact numbers to reach you in order to help assist us in contacting you. We appreciate your help and look forward to serving your dental needs.

Patient Signature: _____ Date: _____

Parent or Guardian Signature if Minor Patient: _____

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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 Practice.

Please Print Signature: ____

Patient Signature: _____________________________________ Date: ________________

Parent or Guardian Signature if Minor Patient: ___________________________________

••

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):____

____

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Medical History Update Form

Date: ________________

Health Changes? ☐ Yes ☐No   Describe: ______________________________________

Medication Changes? ☐ Yes ☐ No List: ______________________________________

Patient Signature: ____

DDS Signature : ____

Date: ________________

Health Changes? ☐ Yes ☐No   Describe: ______________________________________

Medication Changes? ☐ Yes ☐ No List: ______________________________________

Patient Signature: ____

DDS Signature : ____

Date: ________________

Health Changes? ☐ Yes ☐No   Describe: ______________________________________

Medication Changes? ☐ Yes ☐ No List: ______________________________________

Patient Signature: ____

DDS Signature : ____

Date: ________________

Health Changes? ☐ Yes ☐No   Describe: ______________________________________

Medication Changes? ☐ Yes ☐ No List: ______________________________________

Patient Signature: ____

DDS Signature : ____

Date: ________________

Health Changes? ☐ Yes ☐No   Describe: ______________________________________

Medication Changes? ☐ Yes ☐ No List: ______________________________________

Patient Signature: ____

DDS Signature : ____