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 (___) _____

Patients Social Security Number _____

Patients Drivers Lic # _____

Spouse Name _____

How did you hear about our office? _____

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.

Employer_____

Responsible Party Signature: _____
Relationship to Insured: Self _____ Spouse_____ Child_____

Smile Survey

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	Smile Makeover	TMJ Splints
Implants	Teeth Whitening	Sleep Apnea/Snore Appliance
Straighter Teeth	Veneers	Fresh Breath

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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

Yes	No	Conditions
☐	☐	HIV + AIDS
☐	☐	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? _____

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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 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 taken 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.

Payments:

- We accept 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 to help assist us in contacting you. We appreciate your help and look forward to serving your dental needs.

If you no show your appointment or fail to give us a 24 hr notice your card maybe charged the fee.

Patient Name:_____
Responsible Party (if different than patient) _____
Please circle credit card: Visa Master Card Amex Discover
Credit Card #_____
Exp. Date_____
CC security (3 digit code) _____
Card holder signature: _____
Date_____
Print name: _____

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 prevented us from obtaining acknowledgement
☐ Other (Please Specify):____
____

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Insurance and Financial Policies

Thank you for choosing our office for your dental needs. We would like to make you aware of some changes to our Insurance and Financial policies. We strive to maintain quality dentistry with compassion and in a comfortable and friendly environment. We hope that you and your family will feel welcome in our office.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options:

Dental Insurance- If you have dental insurance, as a courtesy to you, we will verify your dental insurance policy and submit your claims to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointments we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____ (please initial)

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

If your insurance company has not made a payment within 90 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.)

Payment is due at the time treatment is rendered. We accept Cash, Personal checks, credit and debit cards, carecredit and HSA/Flex cards.

If you need to make long-term payments we can offer financing through CareCredit up to 12 months. Any financial agreements will need to be completed before treatment is rendered.

All patients with and outstanding balance will receive a statement each month. There is a finance charge of 1.5% (18% APR) on all accounts 60 days overdue. If you have a returned check you will be charged a return check fee of $50.00/ check in addition to any fees your bank charges. _____ (please initial)

We reserve the right to charge for appointments broken without proper 24 business hours notice. There is a minimum fee of $75 per hour scheduled.

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MINOR PATIENTS: The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, a MC/Visa, check or cash payment is paid on the account at the time of service.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees, court costs, interest and any other charges incurred to collect this account. In the event that the account is turned over to collections you will need to discuss all payment arrangements with the collection agency.

Patient Signature: _____ Date: _____

Parent or Guardian Signature if Minor Patient: _____