TIME 04:11 PM DATE 11/9/2018

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

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

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

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: State / Zip: Pager:

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

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By

Previous Dentist

Emergency Contact

Emergency Contact #

Primary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

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

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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	
Have you ever been hospitalized or had a major operation?	☐ Yes ☐ No	If yes	
Have you ever had a serious head or neck injury?	☐ Yes ☐ No	If yes	
Are you taking any medications, pills, or drugs?	☐ Yes ☐ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes ☐ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐ Yes ☐ No	If yes	
Are you on a special diet?	☐ Yes ☐ No		
Do you use tobacco?	☐ Yes ☐ No		
Do you use controlled substances?	☐ Yes ☐ No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

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

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

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:

X Date:_____

Consent Statement

Crosby Dental Center
6618 FM 2100, Crosby, Texas 77532
281-328-3569

Date: _____

I, _____, hereby authorize and request the performance of dental services provided by Dr. Jim Nored DDS and/or Dr. Hale McDaniel DDS. I also give consent to any advisable and necessary dental procedures, medications, and anesthetics to be administered by Dr. Jim Nored or by the supervised staff for diagnostic purposes or dental treatment.

_____
(Signature of Patient)

For Child / Minors

Date: _____

I, _____, hereby authorize and request the performance of dental services provided by Dr. Jim Nored and/or Dr Hale McDaniel for:

_____ Age: _____

_____ Age: _____

_____ Age: _____

I also give consent to any advisable and necessary dental procedures, medications, and anesthetics to be administered by Dr. Jim Nored or by the supervised staff for diagnostic purposes or dental treatment.

_____ _____
(Signature of Parent / Guardian) (Relationship to other(s) named)

Crosby Dental Center

6618 FM 2100 Rd, Crosby, Texas 77532
281-328-3569

Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payments for services are due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover, American Express and Care Credit. We will file with your insurance company. A deposit maybe required on all scheduled treatment unless other arrangements have been made and approved by our financial administrator.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies to companies who pay a percentage (such as 50% or 80%) of UCR, which is defined as usual and customary rates by the insurance company.

3. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services that are not covered.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of the insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the service is rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help YOU.

Signature: _____

Date: _____

Crosby Dental Center

6618 FM 2100 Rd., Crosby, TX 77532
(281)328-3569 (Phone) ♦ (281)328-3560 (Fax)

WARRANTY INFORMATION FOR SERVICES RENDERED

This Limited Warranty is made between Crosby Dental Center and the patient in an effort to maintain your dental health. We will repair or replace without charge any covered treatment provided that the patient has fulfilled his or her patient responsibilities as described herein.

Patient Responsibilities

The patient must maintain regular hygiene appointments. Routine exam and cleaning every 6 months or as otherwise directed. And x-rays every 12 months for diagnostic purposes. Additional Implant information on page 2.

Recommended work related to the work being warrantied must be done in an effort to maintain the best prognosis.

If it is determined that you "clench" or "grind" your teeth, you will be required to purchase a bite appliance. The bite appliance must be worn as prescribed for warranty to stay in effect.

What is Not Covered

Failure of a Covered Treatment due to failure of Patient to comply with his or her Patient Responsibilities, other treatments, medical conditions resulting from substance abuse, medical conditions that cause damage to oral structures including the supporting bone around implants and/or loss or destruction of a removable prosthetic or appliance.

Treatments Eligible For Coverage

12 Month Warranty: Fillings, Bondings, Buildups, Posts, Implant Abutments, Bite Splints, Bruxism Guards, Snore Guards, Retainers and Root Canals.

5 Year Warranty: Crowns, Veneers, Bridges, Implants, Implant Crowns, Dentures, and Partial Dentures.

Dental Implants Warranty

In order to keep this warranty in effect, you must agree to the following:

You will allow us to perform the necessary therapy to eliminate your oral health problems, and restore your bite.

If it is determined that you "clench" or "grind" your teeth you will be required to purchase a bite appliance.

You will wear any necessary bite appliance as prescribed.

You will be faithful to the checkup and cleaning schedule to ensure your long term oral health.

You will not smoke or use tobacco products. The use of tobacco or smoking voids the implant warranty. No exceptions.

Patient Signature:_____ Date:_____

Patient Name:_____
If minor, indicate relationship to patient.

Crosby Dental Center

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**.

_____
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

SUMBIT