2212 Same Rayburn Hwy
Suite 300
Melissa, TX 75454
(972) 837-2929

Notice of Privacy Practices Acknowledgement

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment information from third parties
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- I also authorize the representatives of Paradise Dental to leave messages on my answering machine / voicemail regarding any and all appointments.

I acknowledge that I have read and understood the provided *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* at any time and that I may contact this organization at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Signature:_____

Date:_____

Please list the names of any other persons you give permission to obtain your personal health/dental information:

_____

Relationship to patient:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below.

Date:_____ Initials:_____ Reason:_____

Paradise Dental, PA
2212 Sam Raybum Hwy
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Melissa, TX 75454
972-837-2929

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION			
Date:			
First Name:	Last Name:		M.I.:
Prefers to be called by:			
Address:			
City:	State:	ZIP:	
Home Phone:	Cell:	Email:	
Birthdate:	Age:	Gender: ☐ Male ☐ Female	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			
Drivers License No.:	Social Security No.:		

GETTING TO KNOW YOU	
Is another member of your family or relative a patient at our office?	
You were referred by:	
Emergency Contact:	**Relationship:**
Emergency Contact Phone Number:	

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
Patient Is: ☐ Policy Holder ☐ Responsible Party (Skip if patient is responsible party)			
Responsible Party:			
First Name:	Last Name:		M.I.:
Address:			
City:	State:	ZIP:	
Birthdate:	Home Phone:	Cell Phone:	
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student			
Drivers License No.:	Social Security No.:		

PRIMARY INSURANCE INFORMATION	
Name of Insured:	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Social Security No.:	Birthdate:
Employer:	Ins. Company:

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18%APR) may be added to my account.

Patient / Parent / Responsible Party's Signature: _____ Date: _____

Patient Name:	Medical Alert:

Medical History

1. Have you been under the care of a medical doctor during the past two years?..... ☐ Yes ☐ No
   If yes, for what? _____
   Physician's Name _____ Phone_____
2. Are you taking any medication or drugs currently, including regular doses of aspirin or over-the-counter herbal medicines?..... ☐ Yes ☐ No
   If yes, please list name and dosage _____
3. Are you aware of having an allergic (**or adverse**) reaction to any medication or substance?..... ☐ Yes ☐ No
   If yes, please list: _____
   Have you been Hospitalized?..... ☐ Yes ☐ No
   If so, for what? _____
4. Indicate which of the following you have had, or have at present.

☐ A.I.D.S	☐ Congenital Heart Disease	☐ Heart Pacemaker	☐ Rheumatic Fever
☐ Allergies or Hives	☐ Contact lenses	☐ Hemophilia	☐ Sickle Cell Disease
☐ Arthritis/Rheumatism	☐ Cortisone Medicine	☐ Hepatitis A B C (circle)	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Diabetes	☐ High Blood Pressure	☐ Stroke
☐ Artificial Joints (hip, knee, etc.)	☐ Diet (Special/Restricted)	☐ Kidney Trouble	☐ Swollen Ankles
☐ Asthma	☐ Emphysema	☐ Latex Sensitivity	☐ Thyroid Problems
☐ Blood Transfusion	☐ Epilepsy or Seizures	☐ Liver Disease	☐ Tuberculosis
☐ Bruise Easily	☐ Fainting or Dizzy Spells	☐ Mitral Valve Prolapse	☐ Tumors
☐ Chemotherapy	☐ Glaucoma	☐ Nervous/Anxious	☐ Ulcers
☐ Chest Pain	☐ Hay Fever	☐ Neurological Disorders	☐ Yellow Jaundice
☐ Chronic Cough	☐ Heart (Surgery, Disease,	☐ Psychiatric/Psychological	
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Radiation Therapy	

8. Do you have or have you had any disease, condition, or problem not listed?..... ☐ Yes ☐ No
   If yes, please list: _____
9. **Women:** Are you pregnant or think you may be pregnant? ☐ Yes _____Months ☐ No **Nursing?** ☐ Yes ☐ No
10. **Women:** Do you use birth control medications? ☐ Yes ☐ No

/ have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. / will notify the dentist of any changes in my health or medication.

Patient/Guardian Signature_____ Date_____

History Review

Dentist Signature_____ Date_____

Paradise Dental

Welcome! Please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for your visit today? _____
_____

Date of last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-Rays**_____
What was done at your last dental visit? _____
_____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Waterpik, toothpick, etc.) _____

Do you have any dental problems now? ☐ **Yes** ☐ **No**
If yes, please describe: _____

Are any of your teeth sensitive to:
☐ Hot or cold? ☐ Sweets? ☐ Biting or Chewing?
☐ Have you noticed any mouth odors or bad tastes?
☐ Do you frequently get cold sores, blisters or any other oral lesions?

Do you:
☐ Clench or grind your teeth while awake or asleep?
☐ Bite your lips or cheeks regularly?
☐ Hold foreign objects with your teeth?
☐ Have Bad breathe while awake or asleep?
☐ Have tired jaws, especially in the morning?
☐ Snore or have any other sleeping disorders?
☐ Smoke/chew tobacco or use other tobacco products?
☐ **Are you satisfied with your teeth's appearance?**
☐ Would you like to keep all of your teeth all of your life?
☐ Do you feel nervous about having dental treatment?
If so, what is your biggest concern?_____
_____
☐ Have you ever had an upsetting dental experience?
If yes, please describe _____

Have you ever had:
☐ Orthodontic treatment? ☐ Oral Surgery? ☐ Periodontal treatment?
☐ Your teeth ground or the bite adjusted?
☐ A bite plate or mouth guard?
☐ A serious injury to the mouth or head?
If so, please describe, including cause _____
_____

Have you experienced:
☐ Clicking or popping of the jaw? ☐ Pain? (joint, ear, side of face)
☐ Difficulty in opening or closing the mouth?
☐ Difficulty in chewing on either side of the mouth?
☐ Headaches, neck aches or shoulder aches?
☐ Sore muscles (neck, shoulders)?
☐ **Do your gums bleed or hurt?**
☐ Have your parents experienced gum disease or tooth loss?
☐ Have you noticed any loose teeth or changes in your bite?
☐ Does food tend to become caught in between your teeth?

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No
If yes, please describe _____
_____
_____

Statement of Office Protocol

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our financial policy.

Payment is due at the time service is provided, unless prior arrangements have been made. Our office accepts cash, personal checks, VISA/MC/Discover/American Express. As a courtesy to our patients, we will submit insurance claims for you; however, all patients are financially responsible for their accounts and all charges incurred are the responsibility of the account holder, regardless of insurance benefits. We will cooperate fully with the regulations and requests of your insurance company that assist in the claim being paid.

Insurance payments are ordinarily received within 20-60 days from the time of filing. If your insurance company has not made payment within **60 days**, we may ask that you contact your insurance company to make sure payment is expected. If payment is not received within **90 days** from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payments from your insurance company after you have paid your bill in full, we will remit the payments directly to you.

APPOINTMENT POLICY

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all of our patients. We want you to know that we make every effort to see you at your scheduled appointment time. We feel that a successful outcome to treatment is the result of combined efforts of both our office team and the patient. Therefore, it is important to adhere to the recommended treatment schedule to obtain optimum results. If you must cancel or reschedule an appointment, we would greatly appreciate that you notify us **at least two business** days prior to your scheduled appointment time. Also, if you arrive more than 10 minutes past your reserved appointment time, you may be asked to reschedule if we are unable to accommodate a late arrival.

Appointments are considered reservations and you will receive a reminder email/text or call prior to all appointments. If we are unable to reach you, we trust that you will keep your reserved appointment. We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We pride ourselves in providing the highest quality of care possible. Please help us maintain this level of care by making your time here a priority.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS REGARDING THE FINANCIAL AND APPOINTMENT POLICY FOR THIS PRACTICE. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

_____	_____	_____
Patient	**Signature of Guarantor, if Minor**	**Date**