

Patient Registration

Patient Information.

First Name _____	Last Name _____	M.I. _____
DOB _____	TXDL _____	SS # _____
Address _____		City/State _____ Zip _____
Home Phone _____	Mobile _____	Work _____ Ext _____
Sex: Male _____ Female _____	Marital Status: Married _____ Single _____ Minor _____ Other _____	
Email _____	Who may we thank for inviting you to our practice? _____	
Reason for today's visit is _____		Date of last dental visit _____
Do you smoke? _____	How often (if yes)? _____	Do you consume alcohol? _____ How often (if yes)? _____

Responsible Party(if someone other than the patient)

First Name _____	Last Name _____	M.I. _____
DOB _____	TXDL _____	SS # _____
Address _____		City/State _____ Zip _____
Home Phone _____	Mobile _____	Work _____ Ext _____
*Please note that all primary insurance policy holders will be defaulted as responsible party.		

Contact Details

Detailed Messages may be left: Home _____ Cell _____ Work _____ No where _____ Other _____				
We <u>may</u> discuss Information regarding treatment, account and appointment reminders with:				
Spouse _____	Parents _____	Children _____	No One _____	Other _____

Notice of Privacy Practices

You as a client have the right to restrict the information we disclose to third parties such as treatments, payments, operations, and any other information obtained during your care with us. We may use or disclose your health information to provide you with reminders (voicemail, email, postcards or letters). You have the right to amend, restrict, and have detail list in which your information was disclosed. We may disclose your health information when we are required to do so by law, have reasonable believe that you are a possible victim of abuse, neglect or violence. You also have the right to get copies of all records with limited exceptions. If you request copies, please notify the office 24 hours ahead of time and there is a charge of \$25.00 per individual record. We will not use your health information for marketing without your written authorization. Questions and Complaints may be filed with: Current Manager, Telephone: 281-392-3022 Fax: 281-392-3013 24210 Westheimer Parkway, Suite 800 Katy, TX 77494 or U.S. Department of Health and Human Services.

Office Financial Policy

Payment is due at the time services are rendered. Insurance benefits are solely determined by your employer and insurance company. Insurance is not a guarantee of payment. We can only estimate your co-pay and deductible and insurance companies may not pay for all of your costs. We will be glad to file your claims. You will be expected to pay in full for services if we are unable to verify prior to treatment. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.

We reserve the right to charge and collect \$25 fee for broken appointments that are cancelled or broken without 24-hours advance notice. Payment plans and financial arrangements can be entered into dental treatments, prior to commencing treatment.

When you provide a check as payment, you authorize us to use information from you check to process a one-time EFT (Electronic Funds Transfer) from you account, or process the payment as a check transaction. You also authorize us to process credit adjustments, if applicable. If your payment is returned unpaid, you authorize us to collect your payment and the return fee amount of 35.00 by EFT(s) or draft(s) from you account.

To the best of my knowledge, the questions on this form have been accurately answered and I fully understand all information written on this form.	
Signature _____	Date _____