**PATIENT REGISTRATION**

First Name:_____Last Name:_____Middle Intial_____

Preferred Name:_____

Patient is: ○ Responsible Party ○ Policy Holder

**Patient Information:**

Address:_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth date:_____ Social Security #_____ Drivers License #_____

Email:_____

Student Status: ○ Full Time ○ Part Time

Preferred Pharmacy:_____

Referred By:_____

**Primary Insurance Information:**

Name of Insured:_____

Birth date:_____

Subscriber ID or Social Security #:_____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Employer:_____ Insurance Company:_____

Address:_____

City, State, Zip:_____

Phone:_____

1644 Research Forest Dr., Suite 130 ○ The Woodlands, TX 77380 ○
Office : 281.681.3300 ○ Fax: 281.681.3301

Timeless Dental

# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

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 Problem ◯ 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 _____

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 _____ DATE _____

# Dental history and consent for treatment

Reason for seeking dental care at this time:_____

Former Dentist:_____ City, State:_____

Date of last dental visit:_____Reason:_____

How often do you: Brush:_____Floss:_____

**How do you feel about dental treatment?**

○ Relaxed
○ A little uneasy
○ Tense
○ Anxious
○ Very Anxious

**Do you have or have you ever had any of the following? Please mark and comment.**

○ Aching or sensitive teeth_____
○ Broken filling_____
○ Areas of food traps_____
○ Unfavorable dental experience_____
○ Sensitive or bleeding gums_____
○ Loose teeth_____
○ Difficulty opening wide_____
○ Growths or lesions_____
○ Broken or missing teeth_____
○ Bad Breath_____
○ Clicking or popping jaw_____
○ Cold Sores_____
○ Grinding or clenching_____
○ Swollen glands_____
○ Dry mouth_____
○ Swelling or lumps in mouth_____
○ Gum infection_____
○ Orthodontic treatment_____
○ Other

**If you could change your smile, what would you change?**

○ Remove unsightly fillings
○ Straighten teeth
○ Change shape of teeth
○ Close gaps in teeth
○ Replace missing teeth
○ Whitening
○ Make teeth same color
○ Other_____

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# OFFICE & FINANCIAL POLICIES

Welcome and thank you for choosing Dr. John Rodriguez's office for your dental care. We are committed to providing you with the highest quality dental care, in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

**Insurance:** When making an appointment with Dr. Rodriguez**, it is your responsibility to confirm with your insurance company that Dr. Rodriguez is currently under contract with your plan. The patient is responsible for knowing their insurance benefit coverage.** We will gladly file your insurance claim on your behalf, but do remember this is a courtesy that our office offers. **We allow 60 days from the date a claim is filed for the insurance company to pay. If your insurance carrier does NOT pay within this time, you will be responsible for the entire balance, and the timely payment of your account**. We will be happy to provide any information for you to provide your insurance carrier for *direct reimbursement to you*. For the insurance companies we are not in network with you will be responsible for the difference not paid by your insurance company.

**Checkout:** Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-pays deductibles or fees for non-covered services will be required at the time of service. For your convenience, we take cash, check, MasterCard, Visa, Discover and Care Credit.

**Late arrivals:** We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 10 minutes past your scheduled appointment time, we will have to reschedule your appointment so that other patients are not inconvenienced.

**No shows and cancellations:** Office hours are by appointment only and we do value your time. Appointment time is reserved for you alone. We do understand that emergencies happen, appointments are missed and is taken into consideration. However, we do require a 24-hour advance notice if you must cancel your appointment, we offer reminder calls/text/emails prior to your appointment; do remember this service is a courtesy. **There will be a charge of $50 per half hour for all no-shows, for every appointment cancelled in less than 24 hours. We reserve the right to double booking.** This means that for future appointments we can book other patients appointments along side of yours, resulting in more wait time on your behalf.

**Emergencies:** Dental emergencies may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will understand the emergency situation. At some point, they may need the same courtesy too!

**I have read and understand the above policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.**

Patient/Parent Signature: _____ Date: _____

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

****You may refuse to sign the Acknowledgement****

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By signing below, you are acknowledging receipt of and understanding of this office's Privacy Practices which describes how health information about you may be used and disclosed and how to gain access to this information for yourself.

_____

Print Name

_____ _____

Signature Date

FOR OFFICE USE ONLY, PLEASE DO NOT WRITE BELOW THIS LINE

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We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained due to:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

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# ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

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We are happy to assist you by filing your insurance claim, but we do ask that you pay your **estimated** patient portion at each treatment visit. Please keep in mind this is only and **estimate**, and your financial responsibility may be more depending on coverage. You are responsible at all times for giving the office any changes with your insurance plan. The office is not held liable for any disclaimers/exclusions with in your policy. Please contact your HR Department and/or Policy Manuel for exclusions and restrictions.

***If your insurance has not paid within 60 days, you will be asked to pay balance in full.*** **We will give you any documentation you may need to receive reimbursement from your insurance carrier. Dental benefits quoted by your insurance company or by us are *never* a guarantee of benefit or payment until your claim is actually processed. You are financially responsible for any amount not paid by your insurance policy.**

**PRE-AUTHORIZATIONS ARE NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE CARRIER.**

Signature of Responsible Party _____

Print Name _____Date _____

I hereby authorize payment directly to Timeless Dental, all insurance benefits otherwise payable to me for services rendered. I authorize the above the establishment or provider to release any information required to secure benefit reimbursement. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____

Print Name _____Date _____

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