Austin Perio Health - Patient Registration

Patient Name | **Date of Birth** | **Gender** ☐ Male ☐ Female

Address | **City** | **State** | **Zip Code**

Email Address | **Cell Phone** | **Home Phone**

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Widowed

Have you ever been to our practice?

☐ Yes ☐ No

Has a family member ever been to our practice? ☐ Yes ☐ No **Family member's name?**

How did you hear about us?

☐ Referring Doctor **What is the referring doctor's name?**

☐ Friend/Family **What is your friend's/family's name?**

☐ Google ☐ Bing ☐ Facebook ☐ Other:

Who is the person responsible for this account? ☐ Self ☐ Other

Responsible Party's Information: (*if Other*)

What is the Responsible Party's name?

Responsible Party's Date of Birth

Relationship to Patient

☐ Spouse ☐ Parent ☐ Grandparent ☐ Sibling ☐ Legal Guardian

Responsible Party's Address

Responsible Party's Email Address | **Responsible Party's Cell Phone** | **Responsible Party's Home Phone**

PRIMARY DENTAL INSURANCE (POLICY HOLDER) - (*Please list Name as it appears on your Dental Insurance Card*)

***Please note: If your Primary Insurance is Medicare, we are unable to file your dental insurance claim.

Policy Holder's Name: | **Policy Holder's DOB** | **Gender** ☐ M ☐ F | **Relationship to Patient** ☐ Spouse ☐ Parent ☐ Legal Guardian

Policy Holder's Address | **City** | **State** | **Zip Code**

Policy Holder's Cell Phone | **Policy Holder's Home Phone**

Dental Insurance Company's Name | **Dental Insurance Co. Phone**

Dental Insurance Co. Claims Address | **City** | **State** | **Zip Code**

Policy/Group Number | **Member ID** | **Social Security Number**

Patient Signature: _____ Date: _____

Austin Perio Health - Polices & Practices Consent

RELEASE OF INFORMATION FOR INSURANCE: By my signature below, I give consent to release my healthcare information to my dental insurance companies to process my claim for payment/reimbursement purposes. I am aware that Austin Perio Health doctors are “out-of-network” providers with all dental insurance companies, including Medicare, Medicaid and CHIP. If I do not have dental insurance, I understand that it is my responsibility to provide the office with my dental insurance information, should I become covered by a dental insurance policy in the future.

TREATMENT PLANS: By my signature below, I authorize the doctor and his designated staff to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all radiographs (x–rays) required as a necessary part of this examination. I understand that the doctor and his designated staff will attempt to obtain any available radiographs (x-rays) from my general dentist prior to my appointment, however, it may be necessary to take additional x-rays to diagnose my condition to provide me with an accurate treatment plan. If I am consulting the doctor for an implant, a CT Scan may also be diagnostically necessary. I understand that the cost for a CT Scan is $325.00, which is typically not covered by my dental insurance, however, I can ask the doctor and his designated staff to provide me with a receipt that will allow me to submit this service for possible reimbursement from my medical insurance. In addition, if medically necessary, I authorize the release of any information acquired during my examination and treatment to my other doctors and/or insurance carriers. I agree and consent to the above and I understand that refusal of these diagnostic tools, if necessary, may result in not being able to complete my visit and/or obtain an accurate and comprehensive diagnosis and treatment plan.

FINANCIAL POLICY, FEES & PAYMENTS: Payment is due in full at the time services are performed. We will file your claim to your dental insurance company for your reimbursement of any possible covered charges, however, you are responsible for paying the full charges on the day of service. For treatment more than $500.00, we can file a Pre-Determination of Benefits for you at your request, however, because a Pre-Determination is only an estimate of benefits that may be reimbursed to you from your insurance company based on your plan and eligibility, final reimbursement by your insurance company may vary due to plan types, insurance maximums, deductibles, and co-payments and exclusions. Please remember that we file with your insurance as a courtesy to you, and any dispute concerning final payment by your insurance carrier should be directed to your insurance company for resolution. Additionally, if your PRIMARY insurance coverage is Medicare and your claims have to be filed with Medicare first, we are unable to file any dental insurance claims on your behalf, as we are not a licensed Medicare provider. By my signature below, I am aware and fully understand that I am responsible for paying any charges incurred today, and at any future visits.

CANCELLATION/RESCHEDULE POLICY: We reserve the right to charge for appointments that are cancelled/rescheduled/broken without proper advance notice. For all non-surgical appointments, we request 48 hours advance notice. The cancellation/reschedule/broken fee for non-surgical appointments without proper notice is $45.00. For SURGICAL appointments, due to the length of time that we reserve for you, we require a minimum of TWO WEEKS advance notice. The cancellation/reschedule/broken fee for SURGICAL appointments without proper notice is $250.00. By my signature below, I understand and agree to the above policy.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that a copy of this office’s Notice of Privacy Practices has been made available to me (on the Austin Perio Health website and at the front office kiosk). I understand that if I request a physical copy of this document, it will be provided to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I have read, understand and consent to the policies and practices listed above.

Patient Name

Patient Signature

Date

AUSTIN PERIO HEALTH
MEDICAL AND DENTAL HISTORY

PATIENT NAME: _____ **DOB:** _____

Pharmacy Name: _____ Pharmacy Phone: _____ Pharmacy Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT: Name: _____ Phone: _____ Relationship: _____

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 medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

DENTAL HISTORY:

Who is your current General Dentist: Name: _____ Phone: _____

How often do you see your General Dentist? _____ **Date of last cleaning:** _____

Times a day you brush: ____ floss: ____ Toothbrush you use? ☐ Manual ☐ Electric What type of bristle: ☐ Hard ☐ Medium ☐ Soft

Are you currently in pain? ☐ Yes ☐ No *If Yes, for how long?* _____

Do you currently have, or ever had:

☐ Swollen gums ☐ Bleeding gums ☐ Abscess/infection ☐ Receding gums ☐ Periodontal disease ☐ Bite Issues ☐ Loose teeth
☐ Shifting teeth ☐ Missing teeth ☐ Bad breath/taste ☐ Clicking/popping ☐ Sore jaw joints ☐ Locking jaw ☐ Clenching/grinding
☐ Sensitivity (hot/cold/pressure) ☐ Food caught between teeth ☐ Blisters/cold sores ☐ Lost/broken filling ☐ Chipped/broken tooth
☐ Previous orthodontics ☐ Removable dental appliances

Are you extremely nervous/anxious in the dental office? ☐ Yes ☐ No

Have you ever had gum surgery? ☐ Yes ☐ No (*If yes, please list year, doctor and if treatment was full-mouth or local*):

Comments: _____

General Health Questions:

Does your regular doctor or any specialist that you see require you to take a pre-med antibiotic prior to dental treatment? ☐ Yes ☐ No
If yes, Prescribing doctor's name: _____ *Ph:* _____ *For what condition:* _____

Are you taking Anticoagulants/Blood thinners (such as Coumadin (Warfarin), Plavix, Eliquis, Xarelto, Pradaxa, Aspirin)? ☐ Yes ☐ No
If yes, what kind and how often? _____

Are you taking, or ever taken any bisphosphonate/bone density medications or RANKL inhibitors for osteoporosis/osteopenia such as Fosamax, Boniva, Actonel, Evista, Zometa/Reclast, Prolia or others in the past 12 years? ☐ Yes ☐ No
If yes, what kind and how often? _____

Are you taking, or ever taken **tranquilizers**, **sleeping pills**, **anti-depressants** and/or **muscle relaxers** on a regular basis? ☐ Yes ☐ No
If yes, what kind and how often? _____

Are you taking, or ever taken **narcotics, pain killers/pain management medication** or **stimulants** on a regular basis? ☐ Yes ☐ No
If yes, what kind and how often? _____

Please list any other medications/pills/drugs that you are taking at this time:

_____

Have there been any changes to your general health in the past year? ☐ Yes ☐ No
If yes, please explain: _____

In the past two years, have you been under a physician's care other than routine checkups? ☐ Yes ☐ No
If yes, please explain: _____

Have you been hospitalized or had a major operation in the past five (5) years? ☐ Yes ☐ No
If yes, please explain: _____

Do you have shortness of breath after climbing one flight of stairs? ☐ Yes ☐ No

Have you, or anyone in your family ever had an adverse reaction to sedation medication, local or general anesthesia? ☐ Yes ☐ No
If yes, please explain: _____

Do you consider yourself in good health at this time? ☐ Yes ☐ No

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Women Only: ☐ Pregnant ☐ Nursing ☐ Trying to get pregnant ☐ Taking oral contraceptives
☐ Menopause ☐ Hysterectomy ☐ Taking hormone medication

* *Women note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist regarding additional methods of birth control.*

MEDICAL HISTORY:

HEIGHT: _____ WEIGHT: _____ Gender: ☐ Male ☐ Female

Primary Care Physician's Name: _____ Phone: _____ Date of last physical exam? _____

Medical Allergies - Are you allergic to any of the following? (*Please check all that apply*)

Pain Medications: ☐ Aspirin ☐ Ibuprofen(Advil) ☐ Acetaminophen (Tylenol) ☐ Vicodin/Hydrocodone ☐ Tramadol ☐ Codeine ☐ Demerol

Anxiety Medications: ☐ Alprazolam (Xanax) ☐ Diazepam (Valium) ☐ Lorazepam (Ativan) ☐ Halcion ☐ Nubain ☐ Versed

Antibiotics: ☐ Penicillin ☐ Erythromycin ☐ Azithromycin ☐ Clindamycin (Cleocin) ☐ Cephalexin (Keflex) ☐ Ciprofloxacin (Cipro) ☐ Tetracycline ☐ Doxycycline

Other: ☐ Latex ☐ Iodine ☐ Sulfa Drugs ☐ Sulfites ☐ Metal ☐ Acrylic ☐ Eggs/Yolk ☐ Soy

Local Anesthetics: ☐ Lidocaine ☐ Marcaine ☐ Carbocaine ☐ Epinephrine

Other Allergies (not listed above):

MEDICAL CONDITIONS: Do you have, or have you had, any of the following:

HEART/CARDIAC					
Angina/Chest Pain	☐ Yes ☐ No	Artificial Heart Valve	☐ Yes ☐ No	Cardiac Pacemaker	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Congestive Heart Failure	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Heart Attack/MI	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No	Heart Surgery	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
BLOOD / AUTOIMMUNE					
AIDS	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Difficulty Clotting	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Hepatitis A	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Hypoglycemia	☐ Yes ☐ No	Immunocompromised	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Sickle Cell Disease	☐ Yes ☐ No	Sjogren's syndrome	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Radiation/Chemotherapy	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No		
BONE / SKIN					
Artificial Joint (Hip/Knee/Other)	☐ Yes ☐ No	Arthritis/Gout	☐ Yes ☐ No	Osteopenia	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Osteonecrosis	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Hives or Rash	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No	Swelling of Limbs/Ankles	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	Excessive Thirst/Dry Mouth	☐ Yes ☐ No
HEAD / NECK / BEHAVIORAL					
Alzheimer's Disease	☐ Yes ☐ No	Memory issues	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Parathyroid Disease	☐ Yes ☐ No	Glaucoma/Eye Disease	☐ Yes ☐ No	Head Injury	☐ Yes ☐ No
Neck Injury	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No
Epilepsy/Seizures/Convulsions	☐ Yes ☐ No				
LUNGS / SINUS					
COPD/Breathing Problems	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	Frequent Cough/Bronchitis	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No				
LIVER / KIDNEYS / INTESTINAL					
Kidney Disease/Problems	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	Liver Disease/Jaundice	☐ Yes ☐ No
Stomach Ulcers/Acid Reflux	☐ Yes ☐ No	Frequent Diarrhea/IBS	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
SUBSTANCES					
Drug Addiction	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Smoke/Chew Tobacco/Vape	☐ Yes ☐ No
History of drug abuse	☐ Yes ☐ No	History of Alcohol Abuse	☐ Yes ☐ No	Prolonged Steroid Use	☐ Yes ☐ No

* *IF YOU CHOSE EPILEPSY/SEIZURES/CONVULSIONS, are they*: ☐ Frequent ☐ Infrequent Controlled with medication? ☐ Yes ☐ No

* *IF YOU CHOSE ASTHMA, is it currently being controlled with medications/inhaler*? ☐ Yes ☐ No

* IF YOU CHOSE DIABETES, *is it:* ☐ Borderline/Diet Controlled ☐ Type 1 ☐ Type 2 ☐ Insulin Dependent ☐ Well-controlled ☐ Family History?

Most recent A1C level? _____ Date? _____

Any serious Illness, disease or medical problem not mentioned above? ☐ Yes ☐ No

If yes, please explain: _____

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 my medical status.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

PRINT NAME: _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____

Austin Perio Health - HIPAA / PHI / Privacy Practices Consent

This consent form allows Austin Perio Health to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 and as outlined in the Austin Perio Health Notice of Privacy Practices. Austin Perio Health has made available to me, for my review, a Notice of Privacy Practices which more completely describes such uses and disclosures prior to my signing this consent form.

I agree and consent to the following practice policies:

- I authorize Austin Perio Health to use and securely transmit my personal protected health information (PHI) to me, my general dentist and/or other health care providers and my insurance company in order to carry out treatment, information requests, payment, and health care operations related to my visits with Austin Perio Health.
- I authorize that Austin Perio Health, at my request, may disclose my personal health information to any person(s) that accompany me to my appointment while I meet with the doctor and staff.
- I authorize that Austin Perio Health may disclose my personal health information to the person who I have listed as my emergency contact, and to other individual(s) I have listed below on this form.
- It is the policy of this office to remind patients of their appointments. I authorize that Austin Perio Health may contact me via phone, secure email, or mobile phone text messaging and/or leave messages on my voicemail to confirm appointments and may speak/leave messages with other members of my household regarding my appointments.

By signing this form, I understand the following:

1. I have the right to revoke this consent at any time, and must do so in writing, but Austin Perio Health may still use information to complete any actions that it began prior to my revoking consent, and which rely on my protected health information.
2. Austin Perio Health may refuse service if I revoke this consent.
3. Austin Perio Health may at times electronically transmit my medical records, which could be received in error by a third party. If this should occur, I absolve Austin Perio Health of all liability, as reasonable precautions Under HIPAA guidelines are taken to avoid this type of error from occurring.
4. I have the right to request (in writing), now and in the future, how protected health information is used and/or disclosed to carry out treatment, payment, and health care operations.
5. Austin Perio Health is not required to agree to my requested restrictions if such restrictions would result in altering Austin Perio Health internal policies to conform to my request.
6. Austin Perio Health may at times change, add, delete or modify any of these provisions in accordance with the U.S. Department of Health and Human Services (HHS) HIPAA Privacy Rule and standards to better serve the needs of the both the practice and the patient and that I may obtain revised notices by contacting Austin Perio Health.

I authorize Austin Perio Health to disclose my personal health information to the *additional* following individual(s) below:

Name	**Phone Number**	**Relationship**
Name	**Phone Number**	**Relationship**

I have read, understand, and do hereby consent to the terms set forth in this HIPAA/PHI/Privacy Practices Consent, and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Name	**Date**	**Signature**