**PATIENT REGISTRATION**

Patient Information:

First Name _____ Last Name _____
Preferred Name _____ Birth Date _____
Address _____ City _____
State, Zip_____ Patient Social Security_____
Home Phone_____ Work Phone _____
Cell Phone _____ ☐ I would like to receive correspondences via text
E-Mail _____ ☐ I would like to receive correspondences via e-mail
Emergency Contact Name _____ Ph. # _____
Sex: ○ Male ○ Female Marital Status: ○Married ○Single ○Divorced ○Widowed
Patient Is: ☐ Insurance Policy Holder ☐ Responsible Party ☐ Dependant

Responsible Party (if someone other than the patient):

First Name _____ Last Name _____
Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Birth Date _____
Social Security Number _____

Insurance Information:

Primary Insurance:
Name of Insured _____ Insured Soc Sec _____
Insured Birth Date _____
Relationship to insured: ○ Self ○ Spouse ○ Dependent
Employer _____
Insurance Company _____
Address, City, State, Zip _____
Group # _____ ID #_____

Secondary Insurance:
Name of Insured _____ Insured Soc Sec _____
Insured Birth Date _____
Relationship to insured: ○ Self ○ Spouse ○ Dependent
Employer _____
Insurance Company _____
Address, City, State, Zip _____
Group # _____ ID # _____

*Who May We Thank For Referring you?*

_____

November 2013

# Financial Agreement
## Darren Thomas D.D.S., Inc.

Patient Name: _____ Date: _____

Thank you for choosing our office as your dental health care provider. We believe that every patient deserves quality care, that's why we present you with the best dental solutions for your personal situation. Our goal is to treat each patient with respect and the best care possible. Everyone benefits when office and financial policy arrangements are understood. So that we have a definite understanding in regard to the payment for dental services, the following is our policy effective November 2013.

**Payment is due at the time service is provided. Payments will be collected at the time of arrival.**

**Payment Options:**

1. Cash, Check, Visa, MasterCard, Discover
2. NO INTEREST Payment Plans from Care Credit (subject to credit approval)
   - *Allow you to pay over time with NO INTEREST (if paid within promotional period)
   - *Convenient, low monthly payment plans
3. Three (3) equal monthly payments to our office **with credit card on file**
   - *Option only available for amounts over $250

**Insurance:** Although we file claims for you as a courtesy, your dental insurance is a contract between you, your employer and your insurance company. Your recommended treatment is individually planned and is not based on your dental insurance benefits or lack of benefits. We will file your insurance claims in a timely manner, any claims outstanding after 45 days will become the patients responsibility. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason.

**Outstanding balances** on your account are discouraged and must be cleared before the next appointment for any account member, or within 30 days of treatment. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances, unless you have payment arrangements.

**Delinquent balances** over 90 days will be referred to an outside collection agency and all patients on account will be dismissed from the practice.

**Cancellation and Late Policy:** Your appointment time is reserved for you. If you are late for an appointment, we may not be able to accommodate you. For cancellation we require a 48 hour advanced notice. We understand that sometimes circumstances will prevent you from cancelling 48 hours in advance. Three missed appointment may result in dismissal as a patient.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for legal, collection fees and any other expenses incurred to collect my account. Additionally by signing this form I authorize Darren Thomas D.D.S. Inc., to process credit card transactions initiated by me either by phone or mail and I authorize my credit institution to pay. I also authorize the release of any information required to process insurance claims.

_____

Signature (Patient or responsible party) Date

DARREN THOMAS, D.D.S., INC.
PATIENT CONSENT FORM

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

**CONSENT FOR CARE:** I, with my signature, authorize Darren Thomas, D.D.S. and any employee working under the direction of the dentist to provide dental care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplied related to my dental health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of dental status/function and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professional for care and treatment.

**CONSENT FOR RELEASE OF INFORMATION:** I also authorize Darren Thomas, D.D.S. to furnish information to the identified insurance carriers for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

**CONSENT FOR ASSIGNMENT OF BENEFITS:** I consent to assign all payment for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges incurred.

**CONSENT RELATED TO THE PRIVACY NOTICE:** I have had a chance to review the Practice Privacy Notice. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions.

I understand that this practice may refuse my services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

I also acknowledge that I have received a copy of Darren Thomas D.D.S. Notice of Privacy Practices.

Print Patient Name: _____

Patient/Guardian Signature: _____ Date:_____

If not patient, relationship: _____

TIME Darren K. Thomas, D.D.S. DATE

# 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 _____