Patient Registration

Discovery Park Dental

715 Discovery Blvd., Suite 119, Cedar Park TX 78613 **(512) 260-8330**

Patient Information *(Strictly Confidential)* Today's Date:____________

Please Print

Name: ______________________________ Name you go by____________

S.S. # ________-_______-__________ **Date of Birth** _____/____/______

Address:________________________ **City** _____________ **TX, Zip**______________

Daytime Phone # _________________ **Evening Phone #**_____________________

Home ( ) or Work ( ) Home ( ) or Work ( )

Cell Phone #_________________ **E-Mail** __________________(Initial to accept emails)_____

Check appropriate box: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

If employed, with whom ______________________Work Phone #_________________

If Married, Spouse's name_______________________ Work Phone #________________

Parent, Spouse or Guardian's name: __________________Emg. Phone # ______________

How did you hear about us? ( ) Friend ( ) Family ( ) Online ( ) Flyer ( ) Sign ( ) Other _________

Who may we thank for referring you? ____________________________________

Responsible Party Info. Name: ______________________________

Relationship to patient __________________ Home Phone #____________________

Cell #_____________________ E-Mail________________________________

Date of Birth_________________ Drivers License____________________________

Employer ______________________________ Wk #______________________

Address if different from above______________________________________

Is this person currently a patient in this office YES ( ) NO ( )

Insurance Information Name of insured__________________________

Date of Birth_________ S.S.# ______________ Relationship to Patient__________

Name of Insurance company______________ Ins. Co. Phone #_______________

Name of Employer__________________ Work Phone # ___________________

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: ______________________

ave 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?

Condition		Condition		Condition		Condition	
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: ______________________

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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 ______________

Discovery Park Dental
715 Discovery Blvd., Suite 119, Cedar Park, TX 78613, (512) 260-8330
Dr. Nitya Balan, D.D.S

Insurance and Alternative Benefits Consent (Financial Policy)

Please read carefully

Welcome and thank you for choosing our office for your dental care. Dental treatment is an excellent investment in an individual's health and wellbeing. Our practice is "health centered" rather than "insurance centered" practice. Our treatment recommendations are based on patient needs, not their insurance benefits. We are committed to providing the highest quality of dental care through the use of state-of-the-art technology, equipment, and training. At all times, you can be confident that we will always recommend and provide you with our best services without regard to the limitations imposed by your insurance coverage. To do otherwise would violate our contract with you – A contract we feel morally obliged to honor. We hope that by providing you with our policies in advance, we can prevent misunderstanding and frustration. Should you have any questions, please don't hesitate to ask.

As a Preferred Provider Organization (PPO) for several insurance companies, we want to inform our patients of the benefits for choosing a PP plan through your employer

- ✓ Reduced fees for services due to our agreement with your insurance company
- ✓ At date of services, you, the member, pay for deductibles and copayment
- ✓ We submit the claims to your insurance company

- ***If you have dental insurance:*** Your dental plan is a form of compensation provided by your employer. You can expect the carrier (insurance company) to reimburse you for a portion of our fee. That portion is determined by the contract between your employer and the insurance company. As a convenience to you, we will electronically process your insurance claim the day of your treatment and gladly provide dental x-rays, charting, and a written diagnostic report, to expedite processing.
- As a courtesy, we will obtain limited confirmation of your benefits – mostly for the purpose of giving you an ***estimate*** of coverage. You are responsible for knowing your plan allowances, and informing us of changes to coverage or maximum annual allowance.
- ***Your estimated portion or copay for treatment must be paid at the time of service.***
- If service is not covered by your insurance company, you are ultimately responsible, and you will receive a statement/bill from our office.
- Should you receive a monthly bill from our office due to unpaid treatment services by your insurance company, you are expected to pay the entire remaining balance due for that service in full.
- Unpaid balances will be turned over to a collection agency if you fail to pay. You will also be responsible for any collection fee incurred by this practice attempting to collect.
- We accept Cash, Check, MasterCard, Visa, American Express, and Discover, ***or*** we will assist you with additional financial arrangements such as *CareCredit*.

By signing this form, I acknowledge to having a PPO insurance plan provided by myself or by my employer, the alternate benefit provision may apply to my treatment

All treatment proposed by Discovery Park Dental is an estimate based solely on information received from my insurance company.

I accept full responsibility for the difference between services rendered and actual benefits paid by my insurance company. Furthermore, I understand if any dispute arises between estimated insurance coverage by Discovery Park Dental and the actual coverage by my insurance company, it is my responsibility to pay my balance in full and receive reimbursement directly from my insurance company. As a courtesy, as needed, Discovery Park Dental will file one appeal to my insurance company on my behalf to help resolve payment issues.

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Name (Print)

____

Signature

____

Date

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 and HB 300.
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
3. **Notification** – We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research** - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Funeral Directors** – We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
8. **Marketing** – We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
9. **Food and Drug Administration (FDA)** – We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation** – We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
11. **Public Health** – As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
12. **Law Enforcement** – We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of 7/2013 and will remain in effect until revised.

Discovery Park Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Discovery Park Dental Appointment Cancellation Policy

Please note the cancellation policy at our practice as outlined below. We make every effort to accommodate the needs and convenience of our patients and will do everything possible to be flexible within reason to accommodate changes/cancellations to appointments. However, patients are made aware that we are depriving other equally important patients of valuable care and doctor appointment time by booking appointments in advance. Last minute cancellations, even though they may be unavoidable, cause stress on all parties concerned. We appeal to all of our patients to be conscious of this policy and work with us for the best experience for all our patients.

1. Discovery Park Dental requests a 24-hour cancellation notice for the first cancellation if the appointment is on Tuesday through Friday.
2. We request a 48-hour cancellation notice for appointments on the following Monday, i.e. we ask patients to please let us know by Thursday if they feel they cannot make the appointment on Monday.
3. At the first cancellation, a $25 charge may be applied as an advance payment towards the next visit.
4. Subsequent, repeated cancellations may require 50% payment in advance, particularly for complex procedures that require time commitment from the doctor exceeding 1 hour.
    a. Appointments may also be broken up into smaller ones to allow both doctor and patient better flexibility.

Patient/Responsible Party Name: ______________________________

Patient/Responsible Party Signature: ______________________________

Date of Signature: ______________________________