DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____
Name of Insurance Company(ies) and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

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5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Sleep apnea	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	CPAP Machine	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No			Weight Loss, unexplained	☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Financial Arrangement

Payment is due at the time of service unless prior arrangements have been made.
It is our policy to have a definite arrangement between you, the patient, and this office concerning the payment of the fees for services rendered. If you have any questions regarding the cost of your treatment, please ask our business team for an estimated cost prior to treatment. For your convenience, our office accepts Cash. Check, Visa, Mastercard, Discover, American Express and Care Credit. All emergency dental services or any dental service performed without previous financial arrangements with the business team must be paid for at the time of service.

Patients Not Covered By Dental Insurance
Payment is expected when services are rendered. Financial responsibility on the part of each patient will be determined before treatment. Any dental service performed without previous financial arrangement or verified dental insurance must be paid for at the time of service.

Patients Covered By Dental Insurance
If you have dental insurance, we will be happy to file it for you as a courtesy. However, your insurance is a contract between you and your insurance company. You are responsible for your entire bill regardless of what your insurance company pays. We are a third party providing the service to you. We require that you be responsible for your co-payment and deductible at the time of service. After insurance has been filed and if benefits have not been received within 60 days from your insurance company, then the balance becomes the patient's responsibility.
PLEASE NOTE: ***Our office is committed to helping you maximize your benefits. However, please be aware that insurance companies may deny coverage for certain procedures. If your insurance company denies a claim, or determines a service is not covered, you are responsible for the full, standard fee for that treatment, as outlined in our signed financial policy. Standard Fees will be shown in your treatment plan.***

A refund will be given when the benefits have been received from the insurance company. The office cannot render services in the assumption that your charges will be paid by your insurance company. Any balance exceeding 60 days may have a 10% per annum service charge on the unpaid balance. A $10.00 billing fee is applied to all statements sent over 90 days after the charges were incurred.

In consideration for the professional services rendered to me or at my request by the doctor, I agree to pay for those services in full. I further agree to pay all cost and reasonable attorney fees if the suit be instituted here under. If your account is turned over to a collection agency, a collection fee of 40% of the account balance will be added and must be paid by the patient. I grant my permission to you to telephone me at home or work to discuss matters related to this form. After two consecutive missed appointments, it is our policy not to reschedule you for any further appointments. There is a $25.00 charge for all returned checks for which the balance of the check and the return check fee will be paid for in cash or money order only.

We require 24 hours' notice to reschedule or cancel an appointment. This will enable us to serve other patients that may need emergency dental care. There is a $35.00 charge for a missed appointment if notice is not given.

I have read and understand the above financial and office policy agreement. I have read and understand the Notice Of Privacy Practice (HIPAA) posted in this office and will receive a copy upon request.

Patient Name_____
Date_____
Patient Legal Guardian_____
Date_____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Dr. Kurt Mackie
1677 River Road, Ste 103
Boerne, TX 78006

I, _____, hereby acknowledge that I have received and reviewed a copy of Dr. Kurt Mackie's HIPAA.

I Understand that Dr. Kurt Mackie's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of the revised HIPA Notice of Privacy Practices upon request.

I understand that if I have questions about Dr. Kurt Mackie's HIPA Notice of Privacy Practices, I may contact Dr. Mackie himself.

I understand that it is my right to refuse to sign the Acknowledgement should I choose, and that Dr. Kurt Mackie will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the US Department of Health and Human Services should I be concerned regarding Dr. Kurt Mackie's privacy policies and procedures. For information on how to contact the US Department of Health and Human Services, please ask the front team for assistance.

Patient Signature_____Date_____

Signature of Personal Representative _____ Date_____

Printed Name of Representative_____ Date_____

Authorization to Release Information

This Form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
(Print Name) (Relationship)

_____ _____
(Print Name) (Relationship)

_____ _____
(Printed Name) (Relationship)

Dr. Kurt Mackie made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. Despite these efforts, Dr. Kurt Mackie was unable to obtain signed Acknowledgement for the following reasons:

___ Refusal to Sign Acknowledgement

___ Communication Barriers prohibited obtaining Acknowledgement

___ An Emergency prohibited Me

Other (Please Explain) _____