Red Bud DENTAL

3720 Gattis School Rd., Ste. 500 • Round Rock, TX 78664
www.RedBudFamilyDental.com
P: 512-494-4947
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Patient Registration Information

Patients Full Name: _____ Preferred Name: _____

Social Security Number: _____-_____-_____.

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: _____.
(Street) (City/State/Zip)
Phone Numbers (____) _____ Home# _____ Work# _____.
Email Address: _____.
Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment reminders, administrative updates and health bulletins) **Yes ( ) No ( )**

How did you **hear** about our Practice? _____

Person responsible for payment and Insurance Information

Guarantor Name: _____._____
Social Security Number: _____ - _____ - _____

Insurance Name:_____ Phone number to Insurance_____.
Group #:_____ Member ID# _____.Employer Name_____.
Insurance
Address:_____
_____.

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent
Date of Birth____/____/____ Male ( ) Female ( )
Address: _____
Phone Number: _____
Who may call we in case of an emergency?
Name: _____ Relationship to patient: _____.
Address:_____.
Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y( )N( )
IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Red bud Dental. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

I also authorize the release of the any dental information needed to further my treatment between other dental facilities (i.e.) x/rays, images, and chart notes.

Signature: _____ **Date:** _____.

Medical History Form

Name of Medical Doctor:_____ City/ST/Zip:_____ Phone_____

List all Medications or drugs your are currently taking:

( ) **None**

_____
_____
_____
_____
_____.

Check medications or drugs you are ALLERGIC to:

( )**None**
( ) Aspirin
( )Codeine/other narcotics
( )Erythromycin
( )Latex
( )Local Anesthetics
( )Metals
( ) Penicillin
( )Sulfa Drugs
( )Other:_____

Check any Medical Conditions you may have:

( ) **None**
( ) AIDS/ HIV
( ) Alcohol/Drug Abuse
( ) Anemia/Leukemia
( ) Anorexia/Bulimia
( ) Arthritis
( ) Asthma/Hay fever
( ) BLOOD Clotting Problems
( ) Bronchitis
( ) Cancer/ tumor or growth
( )Cardiac Pacemaker
( )Chest pain
( )Damage Heart Valve
( ) Other:_____
( ) Diabetes
( )Emphysema
( ) Epilepsy
( )Fainting Spells/Seizures
( )Fever Blisters/Herpes
( ) Frequent Headaches
( ) Frequently Dry Mouth
( ) Gall Bladder Trouble
( ) Heart Attack/ Stroke
( )Heart Disease/ Angina
( )Hepatitis/ Jaundice
( )High Blood pressure
( )Hives/ Skin Rash
( )High Cholesterol
( ) Joint replacement, Date:_____
( ) Kidney/Bladder Trouble
( ) Liver Disease
( ) Low Blood Pressure
( ) Mental Health Problems
( )Mitral Valve Prolapse
( )Persistent Diarrhea
( ) Rheumatic fever
( ) Rheumatic Heart Disease
( ) Sexually transmitted Disease
( )Sinus Trouble
( )Thyroid Problems
( )Tuberculosis

Tobacco use? If so what kind and how much?_____.
Unusual reaction to DENTAL injections?_____.
Reason for today's visit:_____.
Are you interested in TEETH whitening?_____.

NEW PATIENTS:
Name of former Dentist_____ City/State:_____
Date of last cleaning and exam_____.

By signing below, I certify all of the above information is true to the best of my knowledge.

_____ _____
Patient/ Guardian Name (PRINTED) Date

_____
Patient / Guardian Signature

_____ _____
Witness Signature Date

ACKNOWLEGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

******You May Refuse to Sign This Acknowledgement******

I_____, have read and received a copy of the office's Notice of Policy Practices.

_____

Patient Name (printed)

_____

Signature of patients (Guardian)

_____

Date

Office & Financial Policies

Thank you for choosing us as your dental health provider. We are devoted to restoring and enhancing the natural beauty of your smile using conservative, state-of-the-art procedures that will result in a beautiful, healthy, and long lasting smile! Please take a moment to review the following office policies and ***initial each one*** *as you read it. If you have any questions, please feel free to ask any staff member for more information.*

APPOINTMENTS

_____ *In order to provide you with the attention and level of care you deserve, we reserve a significant amount of time and reserve a specific room for your visit. We also understand that your time is valuable and, because of that, we make every effort to see you at the appointed time. On the other hand, your promptness and consideration in not changing your reserved time is very much appreciated. In the event you must change an appointment, a minimum 48-hour notice is required.* ***Please note that a fee of $30 will be applied for appointments missed without notice and for broken appointments with less than 24 hours notice.***

_____*Arrangements must be made in advance if a minor child (under age 18) is to be seen without an adult present.*

INSURANCE/FINANCIAL

_____***Treatment Plan fees are valid for 90 days.***

_____*As a courtesy to our patients, we accept assignment of benefits from most insurance companies. However,* ***we do require you to pay your deductible and/or "estimated patient portion" at the time of service.***

_____*Your insurance company may pay alternate benefits for certain procedures such as bridge work.* ***Cosmetic restorations (white fillings), for example, are sometimes paid at a lower rate than our estimate. You will be billed for the remaining balance.***

_____*Some of our services may be "non-covered," subject to an insurance company's arbitrary determination of usual and customary rates, or have time limitations imposed by the insurance company. In addition, there may be a missing tooth clause or other restrictions on your policy that may apply to your treatment and any subsequent payment expected from your insurance carrier. Our fees reflect what is usual and customary for our area, as well as the quality of treatment that you receive.*

You are responsible for the balance left unpaid by your insurance company.

_____*Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Any and all fees quoted for dental treatment are based on the current information provided to us by your insurance carrier.* ***Any differences in payments made by or procedures denied by your insurance carrier are your responsibility.***

_____***It is your responsibility to understand your dental insurance benefits and to inform the office of any changes to your insurance before treatment is performed.***

_____*The adult accompanying a minor is responsible for full payment.*

_____***In the event your account balance remains unpaid in excess of 90 days, your account will be turned over to a collection agency. You will be fully responsible for all admin costs and legal fees associated with the collection process.***

Thank you for reviewing and understanding our guidelines. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above policies.

_____ _____ _____

Patient's Name – Please print Patient's (or Legal Guardian's) Signature *Date*

_____

Witness's Name – Please print Witness's Signature Date