PATIENT REGISTRATION AND MEDICAL HISTORY

Patient: ____

Home Address: ____________________________________City/State/Zip: _________________________________

Sex: M F Date of Birth: ______________________________ SS#: ____

Email Address:____

Please circle one: Single Married Divorced Widowed

Home Phone #: __________________ Work Phone #: __________________ Cell Phone #: ____________________

Your Occupation: ___________________________ Employer: ____

Parent or Guardian of Minor: ____________________________SS# of Parent: _______________________________

Person Responsible for Payment of Account: ____

Whom may we thank for referring you? ____

EMERGENCY INFORMATION: Name: ______________________________ Phone Number: __________________

Relationship ____

Dental Insurance Information (Policyholder Information):

Primary Policy Holder's Name: ____ SS#: ___________________

Date of Birth: ________________ Employer: ____

Employer Address: ____

Insurance Company Name: ____

Insurance ID: ____________________________________ Group #: ______________________________

Employer Phone #: _______________________________________

This information is strictly confidential and WILL NOT be released to anyone without your consent. It is important, for your safety that the Doctor knows about your Medical and Dental history. Please make sure this form is accurately completed to the best of your knowledge.

Patient Signature: ____Date: _______________________________

Aesthetic General Dentistry of Frisco, PLLC

General Medical History:

Abnormal Bleeding	Yes	No	Heart Valve Dysfunction	Yes	No
Abnormal Heart or Previous Bacterial Endocarditis	Yes	No	Hepatitis, Any form	Yes	No
Acid Reflux	Yes	No	Hypertension	Yes	No
Anemia or Blood Disorder	Yes	No	Joint Replacements? When placed?	Yes	No
Antibiotic, pre-medication before dental treatment?	Yes	No	Kidney Disease	Yes	No
Arthritis, Rheumatism, other inflammatory disease	Yes	No	Liver Disease (including Jaundice)	Yes	No
Asthma	Yes	No	Mitral Valve Prolapse	Yes	No
Cancer or Tumor	Yes	No	Osteoporosis	Yes	No
Cholesterol	Yes	No	Pace Maker	Yes	No
Congenital Heart Disease	Yes	No	Previous Biopsies	Yes	No
Diabetes I or II	Yes	No	Psychosis	Yes	No
Emphysema or Respiratory/Lung Illness	Yes	No	Radiation/Chemo Therapy	Yes	No
Epilepsy/Seizures	Yes	No	Rheumatic Fever	Yes	No
Excessive Bleeding	Yes	No	Sinus Problems	Yes	No
Fainting or Dizzy Spells	Yes	No	Slow-Healing Mouth Sores	Yes	No
Glaucoma	Yes	No	Stomach Problems	Yes	No
HIV Infection/AIDS or ARC	Yes	No	Stroke	Yes	No
Head Injury	Yes	No	Thyroid Disease	Yes	No
Heart Disease, Heart Attack, or Heart Surgery	Yes	No	TMJ Disorder	Yes	No
Heart Stent – When placed?	Yes	No	Tuberculosis	Yes	No
Heart Valve (artificial) or Heart Transplant	Yes	No	Ulcers	Yes	No

Question		
Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actones, Boniva, etc.) If so, when did the treatment begin? When did the treatment end?	Yes	No
Are you under the care of a Physician? If so, Why? Physician's Name: ____Phone #: ___________________	Yes	No
Have you been hospitalized within the last 5 years? If yes, please explain	Yes	No
Women only: Are you pregnant? Due Date?	Yes	No
If no, are you planning a pregnancy in the near future?	Yes	No
Are you a nursing mother?	Yes	No
Are you taking birth control pills?	Yes	No

Tobacco Usage: Yes/No Smoke/Chew For How Long?_________________ Frequency?________________

List any medications you are currently taking: ____

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Have you ever had an allergic or adverse reaction to any of the following?

Local/Topical Anesthetics	Yes	No	Penicillin	Yes	No
Nitrous Oxide	Yes	No	Erythromycin	Yes	No
Iodine	Yes	No	Sulfa	Yes	No
Codeine	Yes	No	Ibuprofen	Yes	No
Latex	Yes	No	Aspirin	Yes	No
Any other allergies?				Yes	No

Patient Signature: ____ Date: ___________________________________

Doctor Signature: ____ Date: ___________________________________

Aesthetic General Dentistry of Frisco, PLLC

Insurance Consent

As a courtesy, Aesthetic General Dentistry of Frisco will file your insurance claim and assist in collecting from the insurance company. However, Aesthetic General Dentistry of Frisco does not render services on the assumption that our charges will be paid by the insurance company. The "patient portion" *is only an estimate,* and in the event that the insurance company pays less than the estimated amount, **you are responsible for the unpaid portion.**

We would also like to inform you that most (but not all) insurance companies allow the benefit of amalgam (silver/mercury) fillings instead of composite fillings (tooth colored) and the benefit of full cast crown (metal/gold) instead of porcelain fused to high noble metal crowns on posterior (back) teeth. The cost difference between the two is usually minimal but please be aware, **you will be responsible for the amount that your insurance does not cover.** Please ask any member of our staff to see which benefit your insurance covers and advise them if you would rather have the amalgam fillings or the full cast crown.

Patient Signature: ____________________________________Date: ________________

Appointment Cancellation Policy

At Aesthetic General Dentistry of Frisco, appointments are made in advance by reserving the appropriate time slots to accommodate you and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing, and arranging the set up items prior to your arrival. This ensures that we achieve the highest standard of care and treatment that we pride ourselves on. We, therefore, require at least **48 hours notice prior to cancelling or rescheduling appointments.** Patients who cancel or reschedule their appointment without prior notice will be assessed **a fee of $75.00** to offset the lost production time and estimated amount of time and effort the staff has already spent preparing for the appointment. We look forward to accomplishing all of your dental needs in a comfortable and caring environment.

Patient Signature: ____________________________________Date: ________________

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed of my *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your *Notice of Privacy Practices* prior to signing this consent. I understand that *Aesthetic General Dentistry of Frisco* has the right to change its *Notice of Privacy Practices* from time to time and that I may contact *Aesthetic General Dentistry of Frisco* to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I also give my permission to take my picture at my initial visit to place in my computer dental records - please let us know if you elect not to have your picture taken when registering.

Patient Name: ____

Patient Signature: ____

Relationship to Patient: ____ Date: _________________

Aesthetic General Dentistry of Frisco, PLLC