Patient Registration Form

Patient Information

First Name _____ Last Name _____ Middle Initial _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

How may we contact you for appointment reminders and other communications?

❑ Cell Phone ❑ Email ❑ Text ❑ Home Phone ❑ Work Phone

How were you referred to our office? _____

Birth Date _____ SSN _____ Driver's Lic. _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed

Responsible Party (if other than patient)

First Name _____ Last Name _____ Middle Initial _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ SSN _____ Driver's Lic. _____

❑ Responsible Party is also the policy holder ❑ Primary insurance holder ❑ Secondary insurance holder

Insurance Information

Name of Insured _____ Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Insured SSN _____ Insured Birth Date _____

Employer _____ Employer Street Address _____

Employer City, State, Zip _____

Insurance Company _____ Insurance Street Address _____

Insurance City, State, Zip _____

Medical History

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 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	Radiations	○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 o 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 Convulsions	○Yes ○No	High Cholesterol	○Yes ○No	Scarlett 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	Swollen 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 Joint	○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: _____

CONSENT/AUTHORIZATION FOR RELEASE OF

IDENTIFYING HEALTH INFORMATION:

I hereby give consent to River Rock Dental, PC and all healthcare providers furnishing care at River Rock Dental, to use and disclose my protected health information for the purpose of treatment, payment and healthcare operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf by your representative, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment or healthcare operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted privacy policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted privacy policy before you sign this consent.

We reserve the right to amend the terms of our posted privacy policy. You may obtain a copy of the current policy by asking our office manager for a copy.

PRINT NAME OF PATIENT_____

SIGNATURE_____**DATE**_____

If you are signing as the patient's representative:

PRINT YOUR NAME_____**RELATIONSHIP**_____

ONLY FILL IN THE PART BELOW IF YOU WOULD LIKE TO CANCEL

Cancellation- I hereby void the consent given above:

Print name of patient_____ signature_____

If you are signing as the patient's representative:

Print name of representative_____signature_____

Cancellation will be effective upon receipt: River Rock Dental, PC, 9500 South IH-35, E-400, Austin TX 78748.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I have received, or been provided with a copy of the
Notice of Privacy Practices for River Rock Dental, PC

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: (circle what applies)

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)

Information Provided for by the American Dental Association