Excellence in Family Dentistry, Implants & Periodontics

KATY DENTAL EXPERTS

6840 S MASON RD SUITE 600 KATY, TX 77450

(832) 321 - 5799

PATIENT REGISTRATION

Patient Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Birth Date: _____ Social Security Number: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Email: _____Receive correspondence via ☐ Email ☐ Text ☐ Both

Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed

How did you hear about our office? _____

Previous Dentist Name: _____Phone #: _____

If you could change ANYTHING about your smile, what would it be?

_____

Have you ever considered using whitening products? If so, which kind have you considered?

_____

PRIMARY INSURANCE INFORMATION

Name of Insured: _____Insured Birth Date: _____

Relationship to Insured: _____

Subscriber ID: _____

Employer: _____

Address: _____

City, State, Zip: _____

Insurance Company:

_____

Address: _____

City, State, Zip: _____

Phone Number: _____

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PHYSICIAN INFORMATION

Physician's Name: _____ Phone: _____

Are you under a physician's care now? ☐ Yes ☐ No

If yes, for what reason? _____

Have you ever:

Been hospitalized/had a major operation? ☐ Yes ☐ No Had a serious head or neck injury? ☐ Yes ☐ No

Are you taking any medications, pills, or drugs? Please list: _____

_____

Do you use tobacco? ☐ Yes ☐ No Do you use controlled substances? ☐ Yes ☐ No _____

WOMEN

Are you ____Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ None Known

☐ Metal ☐ Latex ☐ Sulfa ☐ Local Anesthetics

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○Yes ○No	Convulsions	○Yes ○No	Hepatitis B or C	○Yes ○No	Rheumatic Fever	○Yes ○No
Alzheimer's Disease	○Yes ○No	Diabetes	○Yes ○No	Herpes	○Yes ○No	Rheumatism	○Yes ○No
Anaphylaxis	○Yes ○No	Drug Addiction	○Yes ○No	High Blood Pressure	○Yes ○No	Scarlet Fever	○Yes ○No
Anemia	○Yes ○No	Easily Winded	○Yes ○No	High Cholesterol	○Yes ○No	Shingles	○Yes ○No
Angina	○Yes ○No	Emphysema	○Yes ○No	Hives or Rash	○Yes ○No	Sickle Cell Disease	○Yes ○No
Arthritis	○Yes ○No	Epilepsy or Seizures	○Yes ○No	Hypoglycemia	○Yes ○No	Sinus Trouble	○Yes ○No
Artificial Heart Valve	○Yes ○No	Excessive Bleeding	○Yes ○No	Irregular Heartbeat	○Yes ○No	Spina Bifida	○Yes ○No
Artificial Joint	○Yes ○No	Excessive Thirst	○Yes ○No	Kidney Problems	○Yes ○No	Stomach/Intestinal Dise	○Yes ○No
Asthma	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No	Leukemia	○Yes ○No	Stroke	○Yes ○No
Blood Disease	○Yes ○No	Frequent Headaches	○Yes ○No	Liver Disease	○Yes ○No	Swelling of Limbs	○Yes ○No
Blood Transfusion	○Yes ○No	Glaucoma	○Yes ○No	Low Blood Pressure	○Yes ○No	Thyroid Disease	○Yes ○No
Breathing Problems	○Yes ○No	Hay Fever	○Yes ○No	Lung Disease	○Yes ○No	Tonsillitis	○Yes ○No
Bruise Easily	○Yes ○No	Heart Attack/Failure	○Yes ○No	Osteoporosis	○Yes ○No	Tuberculosis	○Yes ○No
Cancer	○Yes ○No	Heart Murmur	○Yes ○No	Pain in Jaw Points	○Yes ○No	Tumors or Growths	○Yes ○No
Chemotherapy	○Yes ○No	Heart Pacemaker	○Yes ○No	Psychiatric Care	○Yes ○No	Ulcers	○Yes ○No
Chest Pains	○Yes ○No	Heart Trouble/Disease	○Yes ○No	Radiation Treatments	○Yes ○No	Venereal Disease	○Yes ○No
Cold Sores/Fever Blister	○Yes ○No	Hemophilia	○Yes ○No	Recent Weight Loss	○Yes ○No		
Congenital Heart Disor	○Yes ○No	Hepatitis A	○Yes ○No	Renal Dialysis	○Yes ○No		

To the best of my knowledge, the question son 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.

X_____ Date:_____

Signature of Patient, Parent or Guardian

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Appointments and Cancellations

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

There is a charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

_____ _____

Patient Signature Date

Please read and sign Notice of Privacy Practices on Back Page

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Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes; treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise those rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of it Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (If signed by a personal representative of patient): _____