CrossroadsDental

Registration Form

Patient Information

Date:

_____ID#/SS#_____

Patient Name: _____

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

Sex: ☐M ☐F Age: _____ Birthdate: _____

☐Married ☐Widowed ☐Single ☐Minor

☐Separated ☐Divorced

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Spouse's Name: _____

Birthdate: _____SS#: _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

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, the undersigned, certify that I (or my dependent) have insurance coverage with _____ 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 hereby authorize the doctor to release all the information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Date Relationship

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____Mobile Phone (_____)_____

Best time and place to reach you _____

Name _____ Relationship _____

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

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

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as 'fen-phen?" These include combinations of lonimin. Adipex. Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dextenfluramine). ☐ 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	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
extractions or surgery	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	neck	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss. Unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ 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
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other _____
_____

CrossroadsDental

Patient/Doctor Bill Of Rights

Thank you for allowing us to provide you with your dental care. We take our job seriously and want you to feel comfortable with us in an environment of mutual respect. We have put together two short lists that will facilitate this.

Patient Bill of Rights

As a patient you have the right to expect the following:

1. Courtesy from the entire staff at every visit.
2. Promptness - we can occasionally run late, and when we do, you deserve to be informed.
3. A neat and clean office — let us know if we ever fail to meet your standards.
4. A thorough explanation of any proposed treatment.
5. Financial arrangements determined in advanced — we will go out of our way to help file your insurance and explain any confusion regarding treatment and fees.

Doctor Bill of Rights

For you to be a patient in our office we ask that you:

1. Be prompt for scheduled appointments.
2. Give us 48 hours notice if you are unable to make your scheduled appointment.
3. Meet your financial obligations at the time of service in accordance with the arrangements that have been made in advance.
   -Your insurance is a contract between you and your insurance company. Ultimately it is your responsibility to understand your insurance policy.
   -An estimate given is just that-an estimate. It is always your responsibility to pay for services rendered. This means that if your insurance doesn't pay what we have anticipated it is your responsibility to pay the balance.
   -Returned checks will be handled through ReChek, Inc. and a $32 processing fee will be applied.
4. Follow pre-treatment and post-treatment recommendations, and return for recall visits when reminded by phone and/or postcard.
5. If you are satisfied with the care you receive from us, you will consider referring your family, friends, and co-workers to us.

We will be happy to go over any of this with you that you might have questions about. If you are dissatisfied with any aspect of care that you receive from our office please let our office manager know!

_____ _____

Signature Date

CrossroadsDental

Payment Policy

This practice depends upon reimbursement from patients for the costs incurred in their care. As condition of your treatment in this office, **payment must be made in advance or on the day services are rendered.** Pre-payment Installments of dental services can be arranged, but must be paid in full by the day of treatment.

For patients with insurance, we verify coverage and file claims as a courtesy to our patients. However, it is up to the patient to understand their own benefits and acknowledge they will be responsible for any treatment not covered by their insurance plan.

We appreciate all our patients and want to ensure we can continue to provide quality care.

_____

Printed name of guarantor or responsible party

_____

Signature of guarantor or responsible party

_____

Date

CrossroadsDental

Welcome to Crossroads Dental Group! We are a general dentistry office focused on providing compassionate care to all our patients. We pride ourselves on being a small, personalized practice, and enjoy taking time to really get to know each patient. Our dentists are highly trained and experienced, and are committed to making sure you are as relaxed and comfortable as possible during your treatments.

Please read our office policies and initial below:

_____ **APPOINTMENTS:** We see patients on an appointment basis. New patients who have completed their Patient Registration and History forms should plan to arrive at least 15 minutes before your scheduled visit. If you have not completed your registration and history forms, and want to complete them when you arrive, please arrive 30 minutes prior to your appointment to complete the forms. If you are an established patient, please arrive 15 minutes before your appointment time.

_____ **IDENTIFICATION:** Each patient or guardian should bring a current driver's license (or other photo ID) and insurance card. This information is necessary for verification purposes.

_____ **APPOINTMENT REMINDERS:** As a courtesy, we typically call you two days before your visit to confirm your appointment. If you need to call to reschedule, or cancel your appointment, please call our office prior to your appointment.

_____**CANCELLED/NO SHOW APPOINTMENTS:** All patients are required to give a 24 hour notice of cancellation or you will incur a S50 charge.

_____ **NO SHOW/CANCELLATION POLICY:** Once a patient has three no-shows, cancellations or a combination, the patient's appointments will only be scheduled as a "same day work-in" on future visits.

_____ **LATE FOR APPOINTMENT:** When patients are late we may get behind on our schedule and this affects other patient's visits. Our policy is that if a patient arrives more than 15 minutes late for their appointment, the patient may be asked to reschedule their appointment, depending on the day's schedule.

_____ **MINORS:** We require prior permission from the parent or guardian to treat any child under the age of 18 years old. Please make sure you sign the signature sheet to give us permission to treat your child in your absence. We will not be able to see any children without this signature. For established child patients, the parent is responsible for keeping the insurance information current on file and making sure the patient is able to pay their responsible portion for each visit. Children under 14 years of age must be accompanied by an adult at all times. Please never leave your child unattended at any time.

_____ **RETURNED CHECKS:** We have a **$25.00** charge for all returned checks.

_____ **REFERRALS:** If your insurance plan requires a referral, you are responsible to see that it is received by our office prior to your visit. Please call ahead to obtain your referral in advance to avoid delays or having to reschedule your appointment. If the referral is not received, you may be asked ter pay for your visit.

_____**CO-PAYS & DEDUCTIBLES:** Payment for copays, deductibles, coinsurance and non-covered services are collected at the time of service. We collect based upon the information provided by your insurance company. Insurance companies and our office require signed consent forms for all surgical procedures (removal of lesions, biopsies, freezing, cosmetic procedures, etc.).

_____ **INSURANCE:** We collect based upon the information provided by your insurance company, so we require patients to be familiar with their benefits. As a courtesy, we verify eligibility and file claims to your insurance company, but it is ultimately up to you to understand what procedures, treatments and materials are covered under your plan, what they pay, and what portion of treatment will be your responsibility.

Printed Name

Signature

Date

We take great pride in the care of each patient in our practice. Please help our office by understanding our policies.

CrossroadsDental

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I _____,have received a copy of this office's Notice of Privacy Practices.

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:

❑ Individual refused to sign

❑ Communications barriers prohibited obtaining the acknowledgement

❑ An emergency situation prevented us from obtaining acknowledgement

❑ Other (Please Specify)

_____

_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 1, 2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right' to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and provide the new Notice at our practice location, and we will distribute it upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

Your Authorization; In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Uses and Disclosures of Health Information

We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credential activities.

To You Or Your Personal Representative: We must disclose your health information to you, as described in the Patient Rights section of this Notice. we may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your absence or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health and Public Benefit: We may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, injury, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purposes; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose you health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that We provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying. If you request copies, we will charge you $0.30 for each page, $17.00 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our Web site or by electronic mail (e-mail)

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Julie Estrada

Telephone: (830) 875-3521 Fax: (830) 875-2212

Address: 409 E. Crockett, Luling, TX 78648 18301875-2212