Patient Registration

First Name* Middle Name Last Name *

_____ _____ _____

Date of Birth * _____ SSN: _____

Gender ○ Male ○ Female ○ Prefer not to say Marital Status _____

Address * _____

City * _____ State * _____ Zip * _____

CONTACT INFORMATION

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

How did you hear about us? _____

Do you consent to receiving any updates/appointment reminders? ○ Email ○ Text ○ Both

RESPONSIBLE PARTY INFORMATION

▢ SAME AS ABOVE

Relationship to Patient* _____

First Name* Middle Name Last Name *

_____ _____ _____

Date of Birth * _____ Cell Phone: _____

Address * _____

City * _____ State * _____ Zip * _____

HULEN SMILES

We are here to serve our patients with excellent dental services. If you have any friends or family members that are in need of dental services, please write their information and we will contact them.

Referrals:

1) Name and Phone Number:
   _____

2) Name and Phone Number:
   _____

Please answer a few questions.

1) What are your concerns today? _____

2) Are you happy with your smile? _____

3) What do you not like about your smile? _____

4) Are you interested in teeth whitening? _____

Preferred Pharmacy information:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Medical History

PATIENT DETAILS

Patient Name: _____ Date of Birth: _____

Gender ○ Male ○ Female ○ Prefer not to say

HEALTH HISTORY

Are you currently under the care of a physician? ○ Yes ○ No

Physician Name:
Physician Phone Number:

Have you ever been hospitalized or had a major operation? ○ Yes ○ No

If yes, please explain:

How would you rate your physical health? (Please circle one)

Good Fair Poor

Have you undergone placement of any metal rods, pins, or implants? ○ Yes ○ No

If yes, please explain:

Have you ever had a serious head or neck injury? ○ Yes ○ No

If yes, please explain:

Do you take, or have you taken, Phen-fen or Redux? ○ Yes ○ No

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Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No

If yes, please explain:

Do you use tobacco in any form? ○ Yes ○ No

Do you use controlled substances? ○ Yes ○ No

If yes, please explain:

Are you on a special diet? * ○Yes ○No

If yes, please explain:

MEDICAL HISTORY

Do you have allergies to any of the following?

▫Aspirin

▫Acrylic

▫Codeine

▫Latex

▫Local Anesthetics

▫Metal

▫Penicillin

▫Sulfa Drugs

▫Other: ▢ NO ALLERGIES

If you answered "Other" please specify/explain:

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

▫Anemia

▫Arthritis

▫Artificial Joints

▫Asthma

▫Blood Disease

▫Cancer

▫Diabetes

▫Dizziness

▫Epilepsy

▫Excessive Bleeding

▫Fainting Glaucoma

▫Head Injuries

▫Heart Disease

▫Heart Murmur

▫Hepatitis

▫High Blood Pressure

▫HIV

▫Jaundice

▫Kidney Disease

▫Liver Disease

▫Mental Disorders

▫Nervous Disorders

▫Pacemaker

▫Pregnancy

▫Radiation Treatment

▫Respiratory Problems

▫Rheumatic Fever

▫Rheumatism

▫Sinus Problems

▫Stomach Problems

▫Stroke ▫Tuberculosis

▫Tumors ▫Ulcers

▫Venereal Disease ▫Other

If you answered "Other" please specify/explain:

Are you currently taking any of the following medications?

▫Aspirin

▫Penicillin

▫Codeine

▫Pre-Med - Amox

▫Pre-Med - Clind

▫Pre-Med - Other

If you answered "Other" please specify/explain:

Patient Signature: _____ Date: ____/____/_____

Hulen Smiles

GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE: I understand that I may be having the following work done: Dental exams, X-rays, Fillings, Cleaning, Fluoride, Scaling & Root Planning, Sealants, Space Maintainer, Night Guard, Pulpotomy, Crown, Bridge, Veneers, Reline, Partial Denture, Denture, Bleaching or any other needed treatment.

2. DRUGS AND MEDICATION: I understand that I will be given antibiotics if needed. I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock.

3. CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.

4. EMERGENCY VISIT: I understand that the treatment provided by my dentist is intended to ONLY eliminate or reduce the infection and/or pain that I am currently experiencing and may not be definitive care. There may be a need for additional procedures to return the state of my mouth to optimum health. Failure to seek additional treatment that my doctor recommends may result in further issues, including pain,

infection, and loss of teeth/bone and/or function.

5. PREGNANT: If in any case, I am pregnant or am thinking to be pregnant, I will inform my dentist before any dental procedure.

INFORMED CONSENT: I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I hereby authorize any of the dentists/dental auxiliaries to proceed with and perform the dental restorations/treatments as explained to me. I understand that my treatment plan is only an estimate and subject to modification depending on unforeseen or undiagnosable circumstances that may arise during the course of treatment.

Patient/Guardian Signature: _____ Date: _____

Financial Policy

Please read this Financial Policy carefully, then sign to acknowledge your understanding and agreement to the terms of the Financial Policy. Thank you for choosing us as your dental care provider. We are committed to providing you with dental care available.

Available Payment Options: **Cash, Check, Visa, Mastercard, American Express, CareCredit**.

Insurance: Coverage and Co-pays

*** For covered services, all co-pays and deductibles must be paid on the day of treatment.** Since your insurance company may not cover all costs, we require that you pay your entire balance of services not covered before treatment can be rendered.

*** For services that are not covered by your insurance, we require that you pay the entire fee before an appointment can be scheduled for treatment.**

***** We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Collections

***** A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

X-Rays

***** You are responsible to pay a fee for duplicate copies of your X-rays.

***Payment arrangements:** I authorize to automatically deduct payments from my account if and when a payment arrangement is made in office and treatment has been rendered.

I hereby authorize payment to Hulen Smiles in Fort Worth, TX by my insurance company, otherwise payable to me.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

Hulen Smiles

Appointment Cancellation Policy

Our goal is to provide quality dental care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call the office as soon as you know you will not be able to make your appointment. We understand that there are true emergencies and it is not always possible to give 24 hours' notice, in these instances we will consider each individual case.

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

Our Policy:

- Any cancellation or reschedule made less than 24 hours in advanced will result in a cancellation fee. The amount of the fee will be $30.00.
- If you are more than 15 minutes late for your appointment, we may not be able to accommodate you. In this case, the same cancellation fee will apply. We will do our very best to reschedule your service for another time that is convenient to you.
- We require a credit card to hold your appointment. Cancellation fees will be charged to your card on file.
- If a patient fails to keep their appointment on a regular basis, or has missed 3 consecutive appointments, they will be considered dismissed from the practice with a letter of dismissal to follow.

Please sign and date below notating that you have received and understood this policy as well as accept the responsibility of its terms.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Hulen Smiles

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):

Obtaining payment from third party payers (Care Credit, Cherry, and Sunbit):

I have been informed of, and given the right to view and secure a copy of your *Notice of Privacy Practices* (available upon request), which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out our treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are bound to comply by these restrictions. I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name_____

Signature_____ Date signed: _____