PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

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

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Update Medical Hx

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

AD Perio And Implants

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ 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 or 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 Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet 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 Problems	◯ 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	Swelling 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 Joints	◯ 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 If yes

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:

X Date:_____

AD Perio & Implants

Anukampa Dutta, DDS, MS
Diplomate, American Board of Periodontology
3301 Oakwell Court, Suite 103, San Antonio, TX 78218
210-805-8400 210-314-5727
info@adperioimplants.com

OFFICE FINANCIAL POLICY

To Our Valued Patients:
We work to make it as easy and convenient as possible for you to receive the periodontal care you need, and we offer several payment options.

Although we are a fee for service practice which means full payment is required at time of service, this simply means we are out of network for your insurance carriers. We are more than happy to help you utilize all the coverage you have with your insurance carrier.

Payment is expected at the time service is rendered. We accept cash, personal checks, or any of the following credit cards: Visa, MasterCard, Discover and American Express. We also accept CareCredit. CareCredit is a third-party financing company that offers both low and no-interest payment plans.

Insured and non-insured patients are expected to make **payment in full** on the day service is rendered.
Since we are an "Out of Network" provider your insurance carrier will provide coverage at their "out of network" rates (which may be lower or higher than their "in network" rates). Our fees are based on usual and customary fees in this area. As a courtesy, our office will file your claims with your insurance carrier, and include all needed correspondences with the purpose of getting you the maximum coverage your insurance will allow. Once your carrier receives and reviews the claim and coverage is approved, they will reimburse you by sending you a check and if your insurance carrier sends us a check by mistake we will issue you a check back within a week of over payment.

I have read the above policies and agree to abide by them.

Signature: _____ Date:_____

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maximize your oral health.

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CANCELLATION POLICY

To Our Valued Patients
We see all patients on an appointment basis and ask that you call in advance so that we can reserve time for you. We try our best to stay on schedule. However, emergencies do occur which occasionally cause delays. If we are delayed we will try to notify you beforehand. Please assist us by being on time for your appointments.

Cancellation Policy:
Due to the fact that we are blocking off designated time of our schedule, it is appreciated that you keep your appointment. **We will remind you 24-hours in advance of your scheduled appointment or on the last working day of the week** (office closed on Fridays). It is at this time that we can make any necessary schedule changes. This courtesy allows us to be of service to other patients. In the event of an emergency/ illness over the week/weekend please leave a message. All messages are listened to in the mornings and on Monday mornings (after the weekend).
In case of last minute cancellations and no-show for a **Consultation/Exam, & Dental Cleaning Appointment** a fee of **$40.00** and in case of missed **Surgery Appointment** a fee of **$200.00** will be posted to your account.

Doctor/Hygienist Cancellations: In the event of a medical emergency or illness of the doctor, hygienist or other staff, we may unfortunately be forced to cancel and reschedule the appointment with you. You will be informed of this as soon as possible

I have read above policies and agree to abide by them.

_____ _____
Signature Date

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HIPAA EMAIL COMMUNICATION CONSENT

Important! Please Read!

* HIPAA stands for the Health Insurance Portability and Accountability Act.
* HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
* Information stored on our computer is encrypted.
* Most popular email services do not utilize encrypted email.
* When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
* Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
* The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 – ALLOW Unencrypted Email

I understand the risks of unencrypted email and do herby give permission to AD Perio and Implants, Dr. Anukampa Dutt to send my dental or my personal health information via unencrypted email when requested.

_____ _____ _____
Signature Date Printed Name
(Parent or guardian if patient is a minor)

_____
Please print email address

OPTION 2 - DO NOT ALLOW Unencrypted Email

I do not wish to receive personal health information via email

_____ _____ _____
Signature Date Printed Name
(Parent or guardian if patient is a minor)

More information can be found at: www.hhs.gov

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PREFERRED METHODS OF CONTACT
(PLEASE CHECK ALL THAT APPLY)

Name: _____

_____Home #: _____

_____Cell #: _____

_____Text _____Call _____Both

_____ Work #: _____**Ext:**_____

_____E-mail: _____

Preferred Pharmacy: _____**Phone:**_____

Signature: _____

Date: _____

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

You may refuse to sign this Acknowledgement

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

_____ _____
Signature Print name

_____
Date

*Privacy Polices are available in office to be read. Copies are available for patients.

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:

1) Individual refused to sign
2) Communications barriers prohibited obtaining the acknowledgment
3) An emergency situation prevented us from obtaining acknowledgment
4) Others (Please Specify) _____

_____

_____