PATIENT REGISTRATION

8200 N Mopac Expressway Suite 120 Austin, TX 78759 Ph: (512) 346-2490 Fax: (512) 346-2490

Patient:

First Name: ______________________ Address: ____
Last Name: ______________________ City: ___________________________
Preferred Name: ______________________ State: _______________ Zip Code: __________

Gender: ❑ Male ❑ Female Home Phone: ____
Birth Date: ______________________ Work Phone: ____
Social Security #: ______________________ Cell Phone: ____
Driver License: ______________________ Email: ____
Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

General Dentist: ______________________ How Long? _______ Phone: ____________________

Emergency Contact Name:	Phone:	Relationship:
____	____________________	___________________________

Responsible Party (*if other than Patient*):

First Name: ______________________ Address: ____
Last Name: ______________________ City: ___________________________
Preferred Name: ______________________ State: _______________ Zip Code: __________

Gender: ❑ Male ❑ Female Home Phone: ____
Birth Date: ______________________ Work Phone: ____
Social Security #: ______________________ Cell Phone: ____
Driver License: ______________________ Email: ____
Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Primary Insurance:

Policy Holder: ________________________
Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other
Policy Holder's Soc. Sec.: ________________________
Policy Holder's Employer: ________________________
Dental Insurance Company: ________________________
Dental Insurance Phone: ________________________
Member ID: ________________________
Group Number: ________________________

Secondary Insurance:

Policy Holder: ________________________
Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other
Policy Holder's Soc. Sec.: ________________________
Policy Holder's Employer: ________________________
Dental Insurance Company: ________________________
Dental Insurance Phone: ________________________
Member ID: ________________________
Group Number: ________________________

Initials _________ **FINANCIAL POLICY:** Office fees and treatment are only an estimate made after reviewing documents received from your insurance carrier via mail, fax or phone and based on your particular insurance plan coverage. Final reimbursement by your insurance company may vary due to insurance maximums, deductibles, and co-payments and exclusions. The patient is responsible for payment of services rendered. Please remember that we file with your insurance as a courtesy to you, and any dispute concerning final payment by your insurance carrier should be directed to the insurance company.

Initials _________ **TREATMENT PLANS:** We will obtain any available radiographs (x-rays) from your general dentist prior to your appointment, however, it may be necessary to take additional x-rays to diagnose your condition in order to provide you with an accurate treatment plan. If you are consulting us for an implant, a CT Scan may also be diagnostically necessary. The cost for a CT Scan is $200.00, which is typically not covered by dental insurance, however, we can provide you with a receipt that will allow you to submit for possible reimbursement from your medical insurance. Your initials acknowledge you have read and understand that refusal of these diagnostic tools, if necessary, may result in not being able to complete your visit.

Initials _________ **CANCELLATION POLICY:** We reserve the right to charge for appointments cancelled or broken without proper advance notice. For all non-surgical appointments, we request 24 hours advance notice. For SURGICAL appointments, due to the length of time that we reserve for you, we require a minimum of TWO WEEKS advance notice. The cancellation/broken appointment fees for non-surgical appointments without proper notice is $35.00, and $100.00 for surgical appointments.

Patient/Responsible Party's Signature: ____ Date: _______________

AUSTIN PERIO HEALTH

MEDICAL AND DENTAL HISTORY

PATIENT NAME____ BIRTH DATE________________ TODAY'S DATE________________

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 medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

MEDICAL HISTORY: HEIGHT: _______________ WEIGHT: _______________

Who is your **Primary Care Physician**, and what is their office phone #?: ____

What is the date of your last complete medical/physical exam? ____

What is your preferred **Pharmacy**, address and phone #? ____

Medical Allergies:

Are you allergic to any of the following?

○ Aspirin	○ Penicillin	○ Codeine	○ Acrylic	○ Tylenol/Acetaminophen
○ Metal	○ Latex	○ Sulfa Drugs	○ Local Anesthetics	○ Clindamycin/Cleocin
○ Iodine	○ Xanax/Valium/ Ativan	○ Tetracycline	○ Versed	○ Nubain
○ Vicodin/Hydrocodone	○ Ibuprofen/Advil	○ Keflex	○ Erythromycin	○ Halcion

Any allergies to any medication not listed above? ○ Yes ○ No (*If yes, please list*): ____

Does your regular doctor or any specialist that you see require you to take a pre-med antibiotic prior to dental treatment? ○ Yes ○ No

Women:

○ Pregnant/Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives? ○ Hysterectomy? ○ Menopause?

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

AIDS/HIV Positive	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Lung Disease	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No
Anemia	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Osteopenia/Osteoporosis	○ Yes ○ No
Angina	○ Yes ○ No	Frequent Diarrhea/IBS	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Glaucoma	○ Yes ○ No	Prolonged Steroid Use	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Head/Neck Injury	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Asthma *	○ Yes ○ No	Heart Attack/MI	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Blood Disease	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Heart Surgery	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Seasonal Allergies	○ Yes ○ No
Bruise Easily/Difficulty Clotting	○ Yes ○ No	Hemophilia	○ Yes ○ No	Shingles	○ Yes ○ No
Cancer	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Chest Pains	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Sleep Apnea	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Stomach Ulcers	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Congestive Heart Failure	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Stroke	○ Yes ○ No
Diabetes *	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Swelling of Limbs/Ankles	○ Yes ○ No
Drug Addiction	○ Yes ○ No	Kidney/Bladder Problems	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Emphysema	○ Yes ○ No	Leukemia	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Epilepsy/Seizures *	○ Yes ○ No	Liver Disease/Jaundice	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No		○ Yes ○ No

* *If Epilepsy/Seizures/Convulsions, are they*: ○ Frequent ○ Infrequent? Controlled with medication? ○ Yes ○ No

* *If Asthma, is it currently being controlled with medications/inhaler*? ○ Yes ○ No

* *If Diabetes, is it:* ○ Borderline/Diet Controlled? ○ Type 1? ○ Type 2? ○ Insulin Dependent? ○ Well-controlled? ○ Family History?

What was your most recent A1C level? ___________ Date? ____________

Any serious Illness, disease or medical problem not mentioned above? ○ Yes ○ No (If yes, please comment below)

Comments: ____

____

Continued on back…

General Questions:

In the past two years, have you been under a physician's care other than routine checkups? ○ Yes ○ No
If yes, please explain: ____________________

Have you been hospitalized or had a major operation in the past year? ○ Yes ○ No
If yes, please explain: ____________________

Are you taking any medications/pills/drugs at this time? ○ Yes ○ No
If yes, please list: ____________________
____

Are you taking anticoagulants (Blood thinners)? ○ Yes ○ No
If yes, what kind and how often? ____________________

Do you use any controlled substances? ○ Yes ○ No
If yes, what kind and how often? ____________________

Do you currently, or have you ever consumed any alcoholic beverages on a daily basis? ○ Yes ○ No
If yes, what kind and how often? ____________________

Do you currently, or have you ever used tobacco products? ○ Yes ○ No
If yes, what kind and how often? ____________________

Do you have shortness of breath after climbing one flight of stairs? ○ Yes ○ No

Have you, or anyone in your family ever had an adverse reaction to sedation medication or anesthesia? ○ Yes ○ No
If yes, please explain: ____________________

Do you consider yourself in good health at this time? ○ Yes ○ No

Have you ever taken any bisphosphonate medications for osteoporosis/osteopenia or bone-related issues? ○ Yes ○ No (*If Yes, please see below:*)

Bisphosphonate Drug Usage:
Bisphosphonates are a group of drugs used to prevent and treat osteoporosis, multiple myeloma, Paget's disease, and bone metastasis from other cancers. With the increased frequency of bisphosphonate use for the treatment of osteoporosis, dentists have been alerted to the possibility of osteonecrosis of the jaw related to these drugs. It is important for our office to know if you are on one of these medications or have taken them in the past. If you have been on a bisphosphonate medication, please alert the office on this form and we will discuss the information that we know that may affect your treatment. Bisphosphonate medications may include one of the drugs listed below. Please be aware that new medications in this group are being added quickly so this list may not always be definitive. Please circle or list the medication that you are currently taken and tell us how long you have been on the drug.
Are you currently taking, or have ever taken the following medications:
Oral Medications: Actonel Boniva Fosamax Skelid Didronel (Other) ____________________
IV/SQ Medications: Prolia Aredia Zometa Bonefos Reclast Xgeva (Other) ____________________

________ I am currently on a bisphosphonate medication and have been on the drug for ______ years.
________ I am not currently on a bisphosphonate medication, however, I have taken a bisphosphonate in the past for ______ months / years, but have not taken it for ________ months / years.

DENTAL HISTORY:

Who is your current General Dentist, and what is their office phone #?: ____________________
How often do you see your General Dentist? ____________________

Are you aware of having or ever had:

- ○ Bleeding gums?
- ○ Gum boil (abscess/infection)?
- ○ Shifting teeth/bite issues?
- ○ Bad breath/bad taste?
- ○ Loose teeth?
- ○ Clicking/popping/sore jaw joints?
- ○ Teeth sensitive to hot/cold/pressure?
- ○ Previous orthodontic work?
- ○ Clenching or grinding?
- ○ Receding gums (longer appearing teeth?

Do you desire to keep your natural teeth? ○ Yes ○ No
Are you extremely nervous/anxious in the dental office? ○ Yes ○ No
Have you ever had gum surgery? ○ Yes ○ No (*If yes, please list year, doctor and if treatment was full-mouth or local*):
Comments: ____________________

What concerns you most about your teeth/gums/mouth?
____

Reason for today's visit?
____

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 my medical status.

PRINT NAME: ____________________

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: ____________________ DATE:____________________

Acknowledgment of Receipt of Notice of Privacy Practices / HIPAA Non-Secure Communication Consent Form / PHI Limited Authorization & Release Form

Patient Name:	**Date of Birth:**

This consent form allows Austin Perio Health to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 and as outlined in the Austin Perio Health Notice of Privacy Practices. This information may be used or disclosed to carry out treatment, payment or health care operations. Austin Perio Health has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures and has provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent. I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting Austin Perio Health.

_______ I authorize Austin Perio Health to use unsecured email and mobile phone text messaging to transmit to me or the following protected health information: 1) Information related to the scheduling of appointments; 2) Information related to billing and payments; 3) Information related to treatment or healthcare options.

_______ I authorize Austin Perio Health to provide updates to my general dentist or other health care providers for patient information requests from them related to my visits with Austin Perio Health.

_______ I authorize that Austin Perio Health may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_______ I hereby authorize that Austin Perio Health may disclose my personal health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff, as well as to the person who I have listed as my emergency contact and the following specific person(s) listed below:

Name	Telephone Number	Relationship to Patient

Furthermore, my (or my child's) personal health information **may NOT** be disclosed to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Austin Perio Health services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Austin Perio Health may refuse service if I revoke this consent.

I understand that my medical records may be transmitted electronically by fax or email and may be received in error by a third party. In the event that this should occur, I absolve Austin Perio Health all liability.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Austin Perio Health is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information. My signature will also serve as a PHI Limited Release should I request treatment or radiographs be sent to other attending doctors in the future.

Signature of Patient or Authorized Representative: ____ **Date:** ___________________

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 laws to maintain the privacy of your health information protected under the Health Insurance Portability and Accountability Act of 1996. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 06/01/2015 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 make Notice available upon request. You may request a copy of 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. 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 credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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.

Family, Friends and Caregivers: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, treatment, medications or with payment for your healthcare, but only if you agree that we may do so. In the case of an emergency where you are unable to tell us what you want, we will use our best judgment when sharing your health information, and only when it will be important to those participating in providing your care.

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 incapacity or emergency circumstances, we will disclose health information based on 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 you best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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. As permitted or required by State of Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order report a crime.

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Abuse or Neglect: We may disclose your health information to appropriate government authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. We will make this
disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law
or with the patient's agreement.

Public Health and 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, counter-intelligence, and other national security or public health activities. We may disclose health information to correctional institutions or law enforcement officials having lawful custody of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, emails, postcards, or letters). Additionally, we may contact you to follow-up on your care and inform you of treatment options or services that may be of interest to you and your family.

PATIENT RIGHTS

Access: You have the right to look at our 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. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. **If you request copies, we will charge you no more than $25.00 for the first 20 pages and $0.15 per page for every copy thereafter.** An additional fee for postage if you want the copies mailed to you.

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 July 21, 2014. 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. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make you request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation 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 if you believe your health information records are incorrect or incomplete. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances where the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Documentation of Health Information
You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage for up to seven (7) years prior to the date requested. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you would like a copy of this Notice, please stop by our office for a paper copy, or give us a call and we will mail or email a copy to you. If you are concerned that your privacy rights have been compromised, you disagree with a decision we made about access to your health information, 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 an alternative location, we encourage you to express any concerns you may have regarding the privacy of your information to us directly. Please let us know of your concerns or complaints in writing. You also may submit a written complaint with the U.S. Department of Health and Human Services. 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.