



Patient Registration

Patient Information

Responsible Party Self Other _____ (Name/Relationship)

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Driver's Lic: _____

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

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

Employment Status: Full Time Part Time Retired Employer: _____

College Student Status: Full Time Part Time Neither School name: _____

Preferred Pharmacy: _____ Pharmacy number: _____

Last Dental visit _____ Reason for today's visit: _____

Are you currently experiencing pain? Yes No How long have you been in pain? _____

Dental Concerns? No Yes _____

Interests/Hobbies: _____

Policy Holder Self Other _____ (Name/Relationship)

Employer: _____ Dental Insurance Company: _____

Group # _____ ID # _____

(Complete information below only if patient is not the policy holder.)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Driver's Lic: _____

How were you referred to our office?

Relative Friend Co-worker Classmate Teacher Name: _____

Money Mailer Direct Mail Postcard Insurance List Signage Yellow Pages Other: _____

For Office Use Only

Information updated in computer



MEDICAL HISTORY

PATIENT NAME _____ Birth 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 medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Women: Are you _____
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psy chiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No _____

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 _____ DATE _____



OFFICE POLICY

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options.

Payment Options:

Payment is due at the time of service. For the convenience of our patients, the following payment options are available:

- **Cash or Check:** A courtesy credit* will be offered for comprehensive treatment plans over \$500.00, when paid in full at the initial appointment (*5% with cash or check and 3% with credit card). A \$25.00 fee will be assessed for all returned checks.
- **Major Credit Cards** We gladly accept Visa, MasterCard, American Express and Discover Credit Cards.
- **Flexible Payment Options** If extensive treatment is recommended, we offer no interest and extended patient payment plans through CareCredit. We assist our patients in the application process.

If you are sent to collections for unpaid account balances, a 35% collections fee will be assessed.

Dental Insurance:

As a **courtesy** to our patients, we are happy to file the forms necessary to see that our patients receive the full benefits of their coverage; however, **we can make no guarantee of any estimated coverage**. Because the insurance policy is an agreement between the patient and their insurance company, we ask that all patients be directly responsible for all charges. If your insurance company does not pay their estimated benefits within 30 days from the date of service, **you are responsible for the entire treatment fee**.

Cancellation Policy:

Our goal is to provide you with quality dental care and personal attention. Your appointment time is reserved *exclusively for you*. If you cannot keep your appointment, please provide 48 hours notice. While we realize there are emergencies, failure to cancel or reschedule an appointment in a timely manner, may result in a cancellation fee of \$25 per ½ hour of reserved time.

Acknowledgement:

I hereby acknowledge and agree to the above office policies; accepting full financial responsibility for my dental treatment.

Date

Patient or Responsible Party

Office/Financial Manager

John C. Sykes, D.D.S., P.A. www.bulverdehillsdental.com Alyssa R. Cobb, D.D.S.
830.980.9004 | 2647 Bulverde Road | Bulverde, Texas 78163 | Fax 830.980.2248



Acknowledgement of Receipt Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy, I agree with the terms of this notice and understand my rights under this notice. **By signing below, I consent for the use of my personal health information for treatment, payment, operations, and other uses as described in the privacy notice.** I also understand that I have the right not to sign this agreement.

Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

Staff Name: _____

Signature: _____

Date: _____