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Suite-146
Southlake, TX 76051
(817)251-9333
www.davincidentistry.com

Patient Registration

First Name: ___________________ Last Name: _________________ Date of Birth: __________

Sex (Circle): Male Female

Home Address: ____

City/State/Zip: ____

Home Phone: _______________________________Cell Phone: __________________________________

Email: ____

Emergency Contact Name: ____

Home Phone: ______________________________Cell Phone: ____________________________________

Relation to Patient: ____

How Did You Hear About Us? ____

Employment: ____

Hobbies: ____

Responsible Party (Insurance Policy Holder):

Full Name: ____

Social Security Number: _______________________ Date of Birth: ___________________________

Insurance Company: ____________________ Employer Name ________________________________

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Dental Treatment Consent Form

Patient Name: ____

Health Information

I agree to disclose all previous illness and medical history. Undisclosed medical information and current medication, allergies or illness are risk factors.

1. **Drugs, Latex and Medicines**
   I understand that antibiotics and other medicines can cause allergic reactions and even life-threatening anaphylaxis. Also, some antibiotics interfere with birth-control pills. Latex allergy can cause rashes and itching. Epinephrine increases heartbeat, and depending on my health, may be dangerous to me.
2. **Needle Stick**
   If someone is inadvertently struck with a needle used on me, I consent to have my blood drawn for analysis.
3. **Fillings, Crowns, and Un-anticipated Root Canals**
   Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a percentage of these teeth end up needing a root canal after the filling or crown is done.
4. **Root Canals can Fail**
   Root Canals can fail and may require additional treatment, or I may end up having the tooth extracted.
5. **Porcelain Crowns, Veneers, Bonding, and Cosmetic Fillings**
   Porcelain crowns, veneers, cosmetic bonding, and composite fillings are esthetically pleasing. However, I understand that if they chip or break after in use successfully, I am responsible for repairs or remakes. Once a crown, veneer, bonding, or filling is placed, I understand the color cannot be changed.
6. **Gum Treatment and Requesting "Just a Cleaning"**
   If I do not floss or if I smoke, I can expect to have deteriorating gum condition. I agree that if I need gum treatment, I will not insist that I simply get a cleaning (prophylaxis).
7. **Extractions and Surgery**
   I understand that all dental extractions or surgeries carry risks. Some are minor like a dry socket following an extraction. Some are life-threatening such as post-surgical infection or anaphylaxis.
8. **Fee for Additional or Specialty Care**
   I understand that I may need treatment beyond what was originally planned (a crowned tooth becomes painful and will need a root canal), or I may be referred to a specialist for additional care (root canal was not successful). I agree to be financially responsible for what insurance does not cover.
9. **Limitations of Insurance Coverage**
   There are charges beyond what insurance will pay, e.g. composite fillings instead of amalgam (silver) fillings, temporary dentures, tapping off crowns or bridges, bleaching or cosmetic work. Also, as a service to patients, this office will file insurance claims on their behalf. I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what the insurance does not cover.

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10. **48 Hour Notice for Cancellation**
    I agree to give 24-hour notice for cancellations or pay the broken appointment fee of $160.00. I understand that leaving a message after the office closed the day (or weekend) before is not sufficient notice.
11. **Requesting Record Transfers**
    Professional Courtesies are between dentists. I agree not to request records until I have a new dentist.
12. **Dental Appointments**
    If I am more than 15 minutes late for my dental appointment, I will either take my remaining time only or reschedule and pay a broken appointment fee.

I hereby acknowledge that no guarantees, warranties, or assurance can be given with treatment and that it will be completely successful in function or appearance (to my complete satisfaction). It is anticipated that treatment will work but because of the uniqueness of each individual and every case and because the practice of dentistry is not an exact science, long-term success cannot be promised.

I have read the above and consent to treatment. I hereby acknowledge that I have read this document and have had the opportunity to ask any questions about anything that I do not fully understand.

_______________________________________ ________________ ______________________
Patient/Parent or Guardian Signature Date Witness Signature

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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.

Question			
Are you under a physician's care now?	Yes	No	If yes, please explain: __________________
Have you ever been hospitalized/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	If yes, please explain: __________________
Are you on a special diet?	Yes	No	If yes, please explain: __________________
Do you use tobacco?	Yes	No	If yes, please explain: __________________
Do you use controlled substances?	Yes	No	If yes, please explain: __________________
Do you need to pre-medicate?	Yes	No	If yes, please explain: __________________

Women only: **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? (Circle)

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please list: ____________________________________

Do you have, or have you had, any of the following? (Circle)

AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet
Fever	Angina	Emphysema	High Blood
Pressure	Shingles	Arthritis/Gout	Epilepsy or
Seizures	Hives or Rash	Sickle Cell Disease	Artificial Heart
Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spina Bifida
Asthma	Fainting Spells/Dizziness	Kidney Problems	
Stomach/Intestinal D.	Blood Disease	Frequent Cough	Leukemia
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of
Limbs	Breathing Problem	Frequent Headaches	Low Blood
Pressure	Thyroid Disease	Bruise Easily	Genital Herpes
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or

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Growths	Chest Pains	Heart Attack/Failure	Parathyroid
Disease	Ulcers	Cold Sores/Fever Blisters	Heart Murmur
Congenital Heart Disorder	Heart Pace Maker	Radiation Treatments	Yellow Jaundice
Convulsions	Heart Trouble/Disease	Recent Weight Loss	

Have you ever had any serious illness not listed above? If yes, please list: ________________________________

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 ____________________

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FINANCIAL AGREEMENT

Thank you for choosing DaVinci Dentistry as your dental provider. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

• You must provide us with an insurance card and all the information necessary to verify you and/or your dependents' coverage and file your claim.

• Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.

• You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.

• Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely **YOUR** responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

• All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

• We accept cash, personal checks, debit cards, AMEX, Visa, MasterCard and Discover.

• After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

• If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due within two weeks.

Initialize ______

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• We do not file claims for medical insurance or more than one dental insurance company per patient.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In
the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A **$25.00** charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve.

We take them seriously so please be considerate and inform us in advance if you need to change your
appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at lease forty-eight (48) hours in advance to avoid a missed appointment fee of $160.00. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

Initials: ____________

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RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of DaVinci Dentistry. Without any reservations, I agree to abide by the policies outlined herein.

Patient Name: ______________________________ Date: ______________________________

Name of person signing this form: ____

Signature: ______________________________ Relationship to patient: ______________

If not patient, are you the person legally responsible for this patient?

Yes/No (Circle One)

Reviewed by staff member: ________________________________ Date: ______________

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DENTAL HISTORY

PATIENT NAME: ______________________________________ DATE:_____________________

1. REASON FOR VISIT: ____
2. DATE OF LAST DENTAL TREATMENT:____
3. ARE YOU HAVING PAIN AT THIS TIME? YES NO
   - HAVE YOU EVER HAD:
   - ORTHODONTIC TREATMENT? YES NO
   - ORAL SURGERY? YES NO

     PERIODONTAL TREATMENT? YES NO

     YOUR TEETH GROUND OR BITE ADJUSTED? YES NO
   - A BITE PLATE, DENTURES OR OTHER APPLIANCE? YES NO
4. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? YES NO
5. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? YES NO
6. DO YOUR GUMS OFTEN BLEED WHEN YOU BRUSH YOUR TEETH? YES NO
7. PROBLEMS OF THE JAW. HAVE YOU EVER EXPERIENCED:
   - CLICKING OF THE JAW? YES NO
   - PAIN (JOINT, EAR, SIDE OF FACE)? YES NO
   - DIFFICULTY IN OPENING AND CLOSING? YES NO
   - DIFFICULTY IN SPEAKING? CHEWING? SWALLOWING? YES NO
   - CHANGES IN THE WAY YOU BITE? YES NO
8. HABITS—DO YOU:
   - CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP?YES NO
   - BITE YOUR LIPS OR CHEECKS REGULARLY? YES NO
   - HOLD FOREIGN OBJECTS WITH YOUR TEETH? (SUCH AS: PENCILS, PIPE, PINS, NAILS, BITE FINGERNAILS?) YES NO
9. DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? YES NO
10. BREATHING ISSUES:
    - DO YOU HAVE BREATHING PROBLEMS? YES NO
    - DO YOU HAVE INTERRUPTED SLEEP PATTERNS? YES NO
    - DO YOU SNORE DURING SLEEP? YES NO
11. ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? YES NO
    IF NO, PLEASE EXPLAIN WHAT YOU WOULD LIKE TO CHANGE ABOUT THE APPEARANCE OF YOUR TEETH:

    ____

    ____

    ____

PATIENT SIGNATURE: ____________________________________

DATE:_____________________

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name: ____

Patient address: ____

Patient phone number: ____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released:
   Name:____ Date: _________________
   Name: ____ Date: _________________

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
   ____

4. Expiration date or event relating to the individual or purpose for the release:
   ____

It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _________________ Patient Signature____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient ____________________ Name_______________________________
Source of Authority___________________________

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PHOTOGRAPHY CONSENT FORM/MODEL RELEASE/MEDIA RELEASE

I, (print name)____________________________________, hereby grant permission to DaVinci Dentistry, its employees, representatives, or affiliates to take and use; photographs/digital images, videotape, audio recording or quoted remarks, educational or other PowerPoint or presentation materials of me and/or my children, for use in our social media (such as Facebook or Twitter) or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and/or children names and identity may be revealed in descriptive text or commentary in connection with the image(s).
I authorize the use of these materials indefinitely without compensation to me. All negatives, positives, prints, digital reproductions and video and audio recordings shall be the property of Davinci Dentistry.

____
(Date)

____
(Signature of adult subject)

____
(Address)

____
(City, State, Zip)

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
-

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- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

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YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional

paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.