north richardson
DENTISTRY ASSOCIATES

610 Old Campbell Rd. #116 - Richardson TX 75080 - (972) 231-2576

PATIENT INFORMATION:

Date:_____ Whom may we thank for referring you?_____

Patient's Name:_____SS#_____
Last First Middle Initial

I prefer to be called: _____

Is there an existing family member's account you wish to be added to?
If so, who _____

Address: _____
City: _____ State:_____ Zip Code:_____
Home #:_____ Cell#:_____ Work#:_____
Email: _____

As a courtesy, we offer appointment confirmation via email, text message or phone.
Please inform us of your preference:

Email *Text* *Home Phone* *Work Phone* *Cell Phone*

Sex: Female Date of Birth_____ Single Married

Employer: _____ Occupation:_____

Emergency Contact:_____ Contact #:_____

INSURANCE/RESPONSIBLE PARTY: *Relationship to Patient*: _____

Subscriber:_____
Last First Middle Initial

SSN: _____ Date of Birth: _____
Employer:_____
Dental Plan Name:_____
Dental Plan Address:_____
Insurance Phone #: _____ Group #:_____ Employee ID#:_____

How did you hear about us? Please mark below:

□ Office Sign □ Dental Team Member □ Friend / Relative □ Insurance □ Flyers / Mail
□ Health Fairs □ Google □ Social Media □ Yelp □ Other

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

Summary:
By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.
As a patient you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.
Please list all telephone numbers where we may contact you:
1. _____2._____ 3._____ 4._____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, GRANDPARENTS, ETC...) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:
Name: _____Relationship:_____
Name:_____ Relationship:_____
Name: _____Relationship:_____

I authorize North Richardson Dentistry to Release my information including diagnosis and the records of any treatment or examination rendered any other healthcare practitioners as necessary for treatment and/or to third party payers.

Acknowledgment of Notice of Privacy Practice and Financial Responsibility

Appointment cancellations must be done more than 24 hours before scheduled appointment time. If the cancellation is made within 24 hours of your scheduled appointment, a cancellation fee in the amount of **$75.00** will be automatically charged to your account.

Please be advised that we can not guarantee any estimates and that there may be a balance after insurance pays. Rarely does an insurance plan cover 100% of your dental treatment. We will do our best to estimate your deductible and insurance co-payment. However, any remaining balance is your direct responsibility. I agree to be responsible for payment of all services rendered on my behalf of my dependents. For your convenience, we accept cash, check and credit cards. We also offer extended payment plans through Care Credit financing.

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice and understand that the practice will offer me an updated copy to the Notice should it be amended, modified, or changed in any way upon my request.

Print Patient Name:_____
Signature of Patient or Legal Guardian:_____ Date:_____

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MEDICAL HISTORY

Patient Name: _____ Preferred Name:_____
Last First Middle

Physician's Name:_____ Office #: _____
Specialist's Name:_____ Office #: _____

Allergies

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Latex ☐ **Aspirin** ☐ **Penicillin** ☐ **Codeine** ☐ **Acrylic** ☐ **Metal** ☐ **Local Anesthetics** ☐
Other If so, please explain_____

Do you require a pre-operative antibiotic before dental treatment? yes no
If yes, reason_____ ☐ ☐

Medications	Dosage	Reason

PAST AND CURRENT MEDICAL CONDITIONS (*mark all that apply*)

□ Heart Disease	□ Heart Murmur	□ High Blood Pressure	□ Blood Disease	□ Rheumatic Fever	□ Venereal Disease
□ Heart Pacemaker	□ Tuberculosis	□ Diabetes	□ Scarlet Fever	□ Anemia	□ Kidney Trouble
□ Seizures	□ Ulcers	□ Emphysema	□ Pain in Jaw Joints	□ Asthma	□ Hay Fever
□ Nervousness	□ Thyroid Disease	□ Chemo: (Cancer)	□ Arthritis	□ Rheumatism	□ Bruise Easily
□ Cortisone	□ Glaucoma	□ HIV + AIDS	□ Hepatitis	□ Hemophilia	□ Sickle Cell Disease

□ **NONE**

Reason for today's dental visit: _____ Date of last dental visit: _____

Are you nervous about dental treatment? **Yes / No** Are your teeth sensitive: **Hot / Cold/ Sweets / Pressure**
Do your gums bleed, feel tender or irritated? **Yes/ No** Do you have discolored teeth that bother you? **Yes / No**
Are you happy with appearance of your teeth? **Yes / No** Are you now seeing a physician? **Yes / No**
Tobacco Use: **Yes / No**
Are you taking any oral Bisphosphonates? **Yes / No** Type:_____
Do you take blood thinners? **Yes / No** Type:_____
Have you had any joint replacements? **Yes / No**
If female, are you pregnant? **Yes / No** Months: _____
Are there any other conditions you feel the doctor should know about or would like to speak in private? YES NO

Signature of Patient, Parent or Gaurdian_____ Date: _____

Medical History Update:

_____ _____ _____
Dr. **Date** **Dr.** **Date** **Dr.** **Date**