

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, 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 \_\_\_\_\_

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 <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 Problems <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	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Veneral 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

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: \_\_\_\_\_

**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  
CONFIRM AFTER NOON \_\_\_\_\_

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: \_\_\_\_\_

Nael Bachour, D.D.S.  
16815 Spring Creek Forest Dr.  
Spring, Texas 77379  
281-370-6911

**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, and 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 the patient: \_\_\_\_\_

Date: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Nael Bachour, D.D.S.  
16815 Spring Creek Forest Dr.  
Spring, Texas 77379  
281-370-6911

**Authorization to Release Personal Health Information**

This authorization is required to release information not generally covered by our privacy notice. Authorization is required for any release not in connection with treatment, payment or operation of our dental practice.

I, \_\_\_\_\_, authorize the release of my personal health information to the following business or individuals:

Family members, insurance companies, pharmacies, dental specialist, schools, physicians

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I authorize this release with full knowledge that this information can no longer be kept secure and private and that I release and indemnify the office of Donald R. Miller, D.D.S., P.A. and its employees from any harm or liability arising from release of said information.

This authorization is for the intended purpose of:

Releasing information to the above.

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This authorization shall expire on December 31, 2020

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship to the Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Nael Bachour, D.D.S.  
16815 Spring Creek Forest Dr.  
Spring, TX 77379  
281-370-6911**

### **Notice of Privacy**

As a provider of medical services we are required, under the Health Insurance Portability and Accountability Act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all patients of their rights regardless of their insurance coverage.

#### **Our Duty to You**

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information about you and your treatment under specific circumstances. These include, but not limited to the following:

**Treatment:** We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers and our staff. Our staff includes full or part time employees as well as temporary personnel.

**Payment:** We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes insurance carriers, claims clearinghouses, collection agencies and third party administrators such as employee medical reimbursement accounts.

**Operations:** We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing, training and certification and accreditation activities.

**Miscellaneous Uses:** At certain times we may require to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages and letters), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operations or payment) and in some cases to law enforcement and court ordered releases.

#### **Your Rights**

**Restrictions:** You have the right to request restrictions on disclosure usage. We are not required to accept these restrictions but we will make note of the request and honor that request if applicable.

**Access:** You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We may/will charge a fee for the copies as set by the Texas State Board of Dental Examiners.

**Amendment:** You have the right to request that we amend your personal health information. Your request must be in writing and explain what should be amended and the rationale for such a request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

**Disclosures:** You have the right to request a list of names and of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operation. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this service if requested more than once in a 12 month period.

**Complaints:** Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy you can submit a written complaint to the United States Department of Health and Human Services. We can provide you with the address upon request.