# DENTAL REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

## 2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

## 3 PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

## 4 DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Bad breath | ☐ Yes | ☐ No | Burning sensation on tongue | ☐ Yes | ☐ No | Mouth breathing | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No | Chew on one side of mouth | ☐ Yes | ☐ No | Mouth pain, brushing | ☐ Yes | ☐ No |
| Blisters on lips or mouth | ☐ Yes | ☐ No | Cigarette, pipe, or cigar smoking | ☐ Yes | ☐ No | Orthodontic treatment | ☐ Yes | ☐ No |
| | | | Clicking or popping jaw | ☐ Yes | ☐ No | Pain around ear | ☐ Yes | ☐ No |
| | | | Dry mouth | ☐ Yes | ☐ No | Periodontal treatment | ☐ Yes | ☐ No |
| | | | Fingernail biting | ☐ Yes | ☐ No | Sensitivity to cold | ☐ Yes | ☐ No |
| | | | Food collection between the teeth | ☐ Yes | ☐ No | Sensitivity to heat | ☐ Yes | ☐ No |
| | | | Foreign objects | ☐ Yes | ☐ No | Sensitivity to sweets | ☐ Yes | ☐ No |
| | | | Grinding teeth | ☐ Yes | ☐ No | Sensitivity when biting | ☐ Yes | ☐ No |
| | | | Gums swollen or tender | ☐ Yes | ☐ No | Sores or growths in your mouth | ☐ Yes | ☐ No |
| | | | Jaw pain or tiredness | ☐ Yes | ☐ No | How often do you floss? _____ | | |
| | | | Lip or cheek biting | ☐ Yes | ☐ No | | | |
| | | | Loose teeth or broken fillings | ☐ Yes | ☐ No | How often do you brush? _____ | | |

## 5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Respiratory Disease | ☐ Yes ☐ No |
| Anemia | ☐ Yes ☐ No | Fainting or dizziness | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Arthritis, Rheumatism | ☐ Yes ☐ No | Glaucoma | ☐ Yes ☐ No | Scarlet Fever | ☐ Yes ☐ No |
| Artificial Heart Valves | ☐ Yes ☐ No | Headaches | ☐ Yes ☐ No | Shortness of Breath | ☐ Yes ☐ No |
| Artificial Joints | ☐ Yes ☐ No | Heart Murmur | ☐ Yes ☐ No | Sinus Trouble | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Heart Problems | ☐ Yes ☐ No | Skin Rash | ☐ Yes ☐ No |
| Back Problems | ☐ Yes ☐ No | Hepatitis Type _____ | ☐ Yes ☐ No | Special Diet | ☐ Yes ☐ No |
| Bleeding abnormally, with extractions or surgery | ☐ Yes ☐ No | Herpes | ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No |
| | | High Blood Pressure | ☐ Yes ☐ No | Swollen Feet or Ankles | ☐ Yes ☐ No |
| Blood Disease | ☐ Yes ☐ No | Jaundice | ☐ Yes ☐ No | Swollen Neck Glands | ☐ Yes ☐ No |
| Cancer | ☐ Yes ☐ No | Jaw Pain | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Chemical Dependency | ☐ Yes ☐ No | Kidney Disease | ☐ Yes ☐ No | Tonsillitis | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Circulatory Problems | ☐ Yes ☐ No | Low Blood Pressure | ☐ Yes ☐ No | Tumor or growth on head or neck | ☐ Yes ☐ No |
| Congenital Heart Lesions | ☐ Yes ☐ No | Mitral Valve Prolapse | ☐ Yes ☐ No | | |
| Cortisone Treatments | ☐ Yes ☐ No | Nervous Problems | ☐ Yes ☐ No | Ulcer | ☐ Yes ☐ No |
| Cough, persistent or bloody | ☐ Yes ☐ No | Pacemaker | ☐ Yes ☐ No | Venereal Disease | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | Psychiatric Care | ☐ Yes ☐ No | Weight Loss, unexplained | ☐ Yes ☐ No |
| Emphysema | ☐ Yes ☐ No | Radiation Treatment | ☐ Yes ☐ No | | |
| Do you wear contact lenses? | ☐ Yes ☐ No | | | | |

**Women:**

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

| | |
|---|---|
| ☐ Aspirin | ☐ Local Anesthetic |
| ☐ Barbiturates (Sleeping pills) | ☐ Penicillin |
| ☐ Codeine | ☐ Sulfa |
| ☐ Iodine | ☐ Other _____ |
| ☐ Latex | _____ |

## 6 UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

# DENTISTS AT LINCOLN GREEN

## PATIENT RESPONSIBILITY FORM

We at Dentists at Lincoln green would like to thank you for the opportunity to provide dental care to you and your family. Essential to providing this care are responsibilities you have as a patient. Please initial each of the following to indicate you have read and fully understand the following terms:

_____ For all appointments, please bring a current insurance card and photo ID and all current medications.

_____ **Late Arrivals**
If you are late arriving for your appointment, we will make every attempt to serve your needs, as time allows and being respectful of previously-scheduled appointments. You may be given the option to wait or invited to reschedule to a time that is more convenient for you.

_____ **Missed Appointments**
If you should need to cancel your appointment, please provide our office with 24 hours' notice. Multiple no-shows can lead to dismissal and/or cancellation fees. Confirmation call is a courtesy. It is essentially your responsibility to know your appointment time and date.

_____ **Insurance Billing**
We participate with multiple insurance companies, but not all. It is your responsibility to know your benefits, who your insurance company participates with, and what they will cover.

_____ **Co-payments**
All copays, deductibles, and payments for non-covered services are **due at check-in**. Unpaid balances will also be collected at this time. If a copayment or balance cannot be paid, the office has the right to reschedule routine appointments until the debt can be paid. We accept cash, check, credit and debit card.

_____ **Collections Policy**
If it becomes necessary to transfer unpaid balances to collection agency, any legal fees associated with those collections will be your full responsibility.

_____ **Returned Checks**
A returned check fee of $30.00 will be charged. We understand sometimes financial problems can occur. During these times, we are willing to work with you to set up alternative payment arrangements if necessary.

_____ _____

Patient/Guarantor Signature Date

# DENTISTS AT LINCOLN GREEN

## Information about Insurance Billing Policies

Dear Valued Patient:

Thank you for choosing our dental practice. The purpose of this letter is to give you information about our billing process.

This is how our billing process usually works:

- Your insurance eligibility and coverage will be verified prior to your appointment.
- Any deductible and/or co-insurance payments associated with your treatment will be determined and explained to you. You are responsible for paying this amount in full on the date of treatment.
- A claim will be sent to your insurance company.
- After your insurance company receives a claim, the insurance company may contact you for additional information. Please respond to your insurance company's questions as quickly as possible so their payment is not delayed.
- It usually takes 14-21 days for your insurance company to pay your claim. After your insurance company pays us, we will provide you with information about any amount you owe.
- You are fully responsible for any amount not paid by your insurance company
- You will not receive further communication from us unless the insurance company has not paid your claim or a balance is due from you (e.g., the part not covered by your insurance or not paid by you at the time of service).

Please keep in mind that your policy is a contract between you and your insurance company. If you did not follow your insurance plan's terms, they may not pay for all or part of your care.

We are pleased to help you with your questions or to provide more information. Our front office staff can be reached at (281)583-9001.

Thank you again for choosing Dentists at Lincoln Green for your health care needs.

Please sign here to acknowledge that you have read and understand your financial responsibility regarding your treatment.

→ _____ _____

Signature Date

_____

Name (Printed)

11307 Veterans Memorial Dr.
Houston, TX 77067
281.583.9001 | 281.583.8968

Dentists at Lincoln Green, PA
11307 Veterans Memorial Dr.
Houston, TX 77067
Tel: 281-583-9001

# Acknowledgement of Privacy Practices

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental providers have the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or heath care operations and I understand that you are not required to agree to my requested restrictions, but if you agree to then you are bound to abide by such restrictions.

Today's Date: _____

Patient's Name: _____

Signature: _____

Relationship to patient: _____

**Dentists at Lincoln Green, PA**
**11307 Veterans Memorial Dr.**
**Houston, TX 77067**
**Tel: 281-583-9001**

# E-mail/ Text Notification Opt-In Consent Form

Dentists at Lincoln Green PA is in the process of offering E-Mail and Text Message notification for Appointment Reminders and other patient care related information. This system will allow you to verify appointment at a time convenient to you, to request future appointments, and to keep you informed of office and patient care information. If you choose to opt-in to this system please provide us with your email address and text messaging number below. This information is only used for Dentists at Lincoln Green PA purposes and is governed by the same HIPAA protection as all other information. We will start utilizing this system once we have enough text/email addresses from our patients' parents/guardians.

Your Name: _____

Patient's Name: _____

**HOW WOULD LIKE US TO CONTACT YOU?**

- **EMAIL**

  _____

- **TEXT MESSAGE**

  _____

- **PHONE**

  _____

I authorize Dentists at Lincoln Green PA to notify me of patient care related information on my E-Mail or Text Messaging (Please circle one or both).

Signature: _____ Date: _____

# Oral Screening Consent Form

**Complete each time the examination is performed and place in the patient's file**

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

**One American dies every hour from oral cancer.** Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Studies also suggest that human papillomavirus (HPV 16/18) plays a role in more than 20% of oral cancer cases.* Oral cancer risk by patient profile is as follows:

***Increased risk:*** *patients ages 18-39*
*-sexually active patients (HPV 16/18)*
***High risk:*** *patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)*
***Highest risk:*** *patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer*

We have recently incorporated ViziLite® Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is _____ .

**No.** I would prefer not to have the ViziLite Plus exam at this time.

Print name: _____

Signature: _____ Date: _____

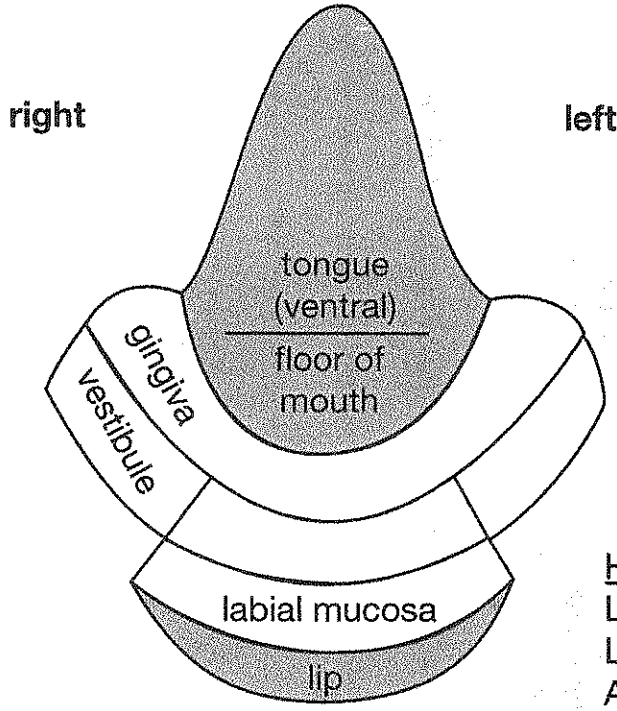
VLP004 – 2/06

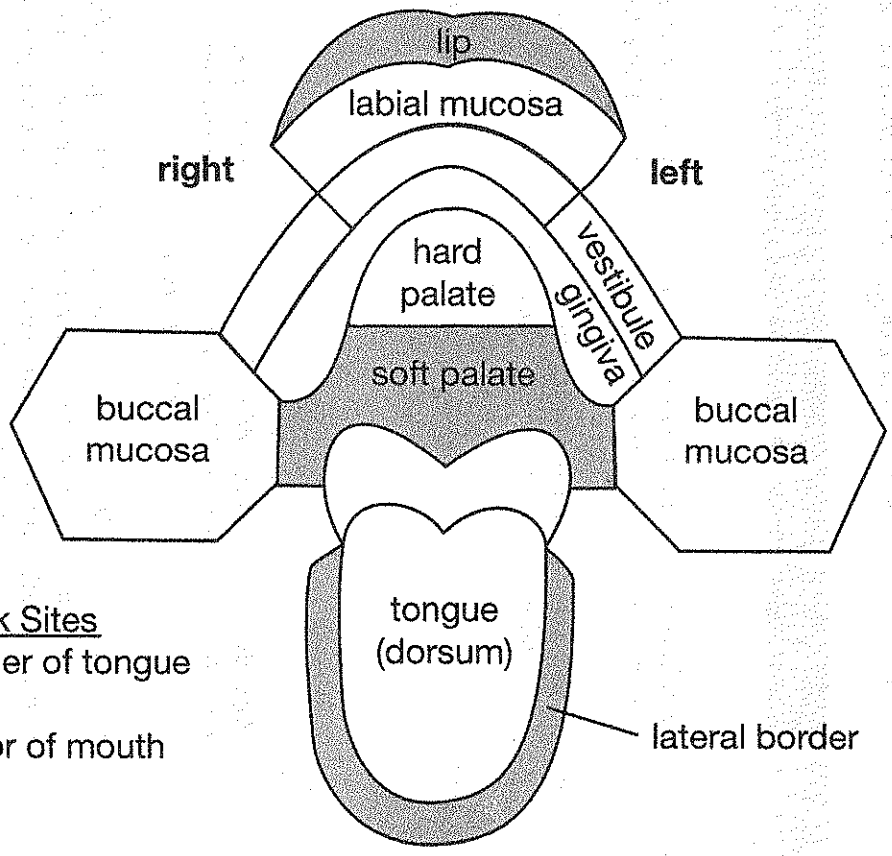
* J Natl Cancer Inst. 2003 Dec 3;95(23):1772-83.

VizilitePlus
ORAL LESION IDENTIFICATION AND MAPPING SYSTEM
Better screening saves lives®
WITH TBLUE®

Patient _____ ID _____

Clinician _____ Date _____




Highest Risk Sites
Lateral border of tongue
Lip
Anterior floor of mouth
Soft palate