Alamo Springs Dental Patient Registration Form

We know that you have many choices when it comes to selecting your dentist. Thank you for giving us the opportunity to provide you and your family with our dental services. Welcome!

Patient Name: Last:_________________________________ First:______________________________ MI:______

Street Address____ City_________________ State_____ Zip___________

Cell Phone:____________________ Home Phone:__________________ Work Phone _____________________________

Employer:____ Email:_____________________________________

Date of Birth:_________________________________ Social Security#:____

If student, name of school:__________________________ **Pharmacy Name & Phone**:____

Emergency Contact:______________________ Relationship______________________ Phone:______________________

How did you hear about us? Please circle/list: Postcard, Drive By, Friend, Family, Internet, Other:________________________

Responsible Party

If the patient listed above IS NOT responsible for payment on this account, please complete the following:

Person Responsible for Account: Last name_________________________ First:_________________________ MI:___

Social Security # of Responsible Party:____________________________

Address:____City_______________________ State:_____ Zip______________

Employer____ Work Phone:_______________________________________

Spouse's Name:______________________________________ Spouse's Employer_________________________________

1. It is **OK** to be contacted about appointments and leave messages in regards to treatment via (***CIRCLE ALL THAT APPLY***):

HOME PHONE **CELL PHONE** **FAX** **TEXT MESSAGE** **EMAIL**

2. I **allow** you to give my clinical information to or answer questions from (***check all that apply***):

☐ Spouse ☐Parent ☐Child ☐Other (specify)_______________________ ☐No One

I, ___________________________________, hereby acknowledge that I have received/read a copy of Alamo Springs Dental's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. (See the Privacy Notice laminated pages at the end of patient forms or framed at the front desk.)

_________________________________ _______________________________

Name Date

I verify that the information is correct. For insurance claims, I authorize the release of any information relating to this claim and the use of photostatic copy of the treatment plan for the services rendered. I authorize payment to Alamo Springs Dental for the insurance benefits otherwise payable to me. I also agree to be responsible for any balance occurring on this account, including any amounts not covered by any dental insurance (insurance pre-determinations are estimates only), pre-payment, capitation or other dental programs. ***Please give our office a 24 hrs notice if unable to make your scheduled appointment to avoid $50 cancellation fee.***

____ __________________________

Signature **Date**

Health History Form

Personal Information

Patient Name:____ Date:_______________
Last First Middle

Sex (circle): Male or Female Date of Birth: ______________

Occupation:________________________________ Date of last dental exam:___________________

If you are completing this form and you are not the patient named above, what is your relationship to this person?

____ ________________________________
Name Relationship

Medical Information

__Note:__ Dr. Anderson and Dr. Moreno encourage you to answer these questions honestly and with detail. Both doctors treat all patients respectfully, and there is no judgement or prejudice. Health conditions you have can affect the health in your mouth. All information is confidential and is used only to help the doctors to propose the safest and most appropriate dental treatment plan for you.

Medical Doctor Name:__________________________ Doctor Phone#:___________________________

Have you had any operations? If yes, please explain:____
____

Are you taking any Herbal Supplements? If yes, please list:______________________________________

Have you taken bisphosphonate medications such as Fosamax, Boniva, Actonel, Atelvia, Reclast? Yes/No

Has your doctor told you to take antibiotics before dental work? Yes/No

Do you use drugs or similar substances for fun? If yes, please list:________________________________

Do you smoke/dip/chew tobacco products? If yes, please list type:________________ How many times a day or week?_____________________________________

Medications

Please List all of your medications or attach a page separately:____
____
____

Health History Form

Allergies

Please **circle and/or list** specifically if you have allergies to any of these items below:

Latex	Sulfa Drugs	Metal
Aspirin	Seasonal Allergies	Ibuprofen/Motrin
Codeine	Sedatives/Sleeping Pills	Antibiotics _________________________

Please list any other allergy not listed:____

Health Conditions

Please circle if you **have** or **had** any of the following conditions. (If not applicable, leave blank.)

Abnormal Bleeding Experience	Fibromyalgia	Cancer:___________________
AIDS or HIV	Infective Endocarditis	Radiation Therapy
Anemia	MRSA	Chemotherapy
Arthritis	Diabetes (Type 1 or Type 2)	Swollen Neck Glands
Asthma	Bulimia	Breathing Problems
Blood Transfusion Date:___________	Seizures	Migraines
Heart Disease/Attack	Acid Reflux	Sexually Transmitted Disease
Heart Valve Replacement/Pacemaker	Glaucoma	Lupus
Autism	Hemophilia	Thyroid
Congenital Heart Defect	Hepatitis (Type: A, B, C)	Frequent Bathroom Breaks
High Blood Pressure	Stroke	Ulcer
Brain/Nerve Disorders	High Cholesterol	Lupus
Kidney Problems	Osteoporosis	Attention Deficit Disorder

Mental Health Diagnosis: Depression, Bipolar Disorder, Schizophrenia, Anxiety Other:______________________
Do you have a condition not listed above? If yes, please list:____

I certify that I have read and understand this form. I will not hold Alamo Springs Dental doctors or staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I will notify my dentist of any changes in my health.

Health History Form

____
Signature of Patient/Legal Guardian

____
Doctor Signature after Review

Updated MEDICAL HISTORY Addendum MARCH 2020

Alamo Springs Dental Medical History

Due to concerns about the spread of viruses like the Flu (Influenza Virus) and the Coronavirus (COVID-19), we have added a few questions that we are asking **all** patients to help keep our patients, team members and doctors informed and safe as possible. Please respond to the questions below.

1. Do you have acute respiratory illness **including frequent cough/sneezing, fever, and/or shortness of breath**?

   YES **NO**

2. Have you had a recent **trip to one of the states or countries that the CDC has listed as high risk for COVID-19 within the past 14 days**?

   YES **NO** **Unsure**

If you are **unsure**, where have you traveled in the past 14 days?____
____

3. Have you had close contact with someone who is under investigation for coronavirus infection?

   YES **NO**

Patient Name PRINTED: I, ___________________________________ have answered these questions to the best of my ability.

Patient Signature: ____ Date: ____________________________

Find more information at: WWW.CDC.GOV/covid19 www.dshs.texas.gov/coronavirus

***Thank you for your cooperation and patience at this time as we do our best to keep our patients and staff safe*.**

Dental Questionnaire

Question		
Are you having any tooth or gum pain today?	Yes	No
Are you nervous about seeing the dentist?	Yes	No
Are you interested in learning about sedation options during treatment?	Yes	No
Have you had any difficulties with previous dental treatment?	Yes	No
Do your gums bleed when you brush?	Yes	No
Do you have missing teeth that you would like to replace?	Yes	No
Are you interested in teeth whitening?	Yes	No
Do you enjoy conversation during your dental treatment?	Yes	No
Are you currently happy with the way your teeth look?	Yes	No

If “no”, what would you change?

____

____

Child Dental Questionnaire

Does your child have tooth pain today? Yes No

Has your child ever fallen and hurt their teeth? Yes No

Is this your child's first visit to the dentist? Yes No

Do you think your child will be nervous or have they had a negative dental experience? Yes No

Do you brush your child's teeth? Yes No

Are you interested in braces for your child? Yes No

Is there anything about your child's teeth that concerns you? If yes, please describe below.

____

____

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Alamo Springs Dental, PLLC Financial Policy Statement

Address: 11590 Galm Rd., Suite 109 San Antonio, TX 78254 | Phone: (210) 463-9339

In an effort to provide you with flexible payment arrangements, we have detailed our payment policy below:

PAYMENT ARRANGEMENTS ARE REQUESTED **AT THE TIME OF YOUR VISIT.** We now offer the following payment options: **Cash, Care Credit, Credit Card** (with a guarantee that any amount not covered by insurance will be billed Discover, American Express, Visa or Master Card).

Also, please remember:

ALAMO SPRINGS DENTAL IS NOT PARTY TO YOUR INSURANCE CONTRACT. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU, YOUR INSURANCE PROVIDER, AND/OR EMPLOYER; therefore,

- **It is the patient's responsibility to report any changes to their insurance plan. These changes may affect how much money is owed to the practice and if not disclosed, you will be responsible for the balance.**
- **Our office verifies benefits and files insurance claims as a courtesy to our patients; however, the patient is responsible for understanding what their plan ultimately covers and any maximums, restrictions that apply.**
- Our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan.
- We cannot be involved in disputes between you and your insurer regarding deductibles, covered fees, co-payments, secondary insurance, and usual and customary charges.
- We will follow the guidelines for patient care, reimbursement and submission of claims for services rendered.
- We do our best to estimate what your insurance will cover and your insurance will be billed promptly following your procedures. You are responsible for any remaining balance on the account at that time.
- Any unpaid balances older than 90 days may be subject to collection placement or collection fees.
- For any credit card on a recurrent payment that fails, the patient is responsible to disclose any changes to the credit card within **30 days** or the incurred balance will be forwarded by the office to a collection agency.

PLEASE GIVE 24-HR NOTICE FOR APPOINTMENT CANCELLATION

- ***We understand that life happens, and if you must cancel or reschedule your appointment, all cancellations must be made at least 24 hours in advance. This allows us to see our patients on time and also helps us give more affordable dental care to all of our patients. If you fail to give 24-hour notice, we charge a $50.00 cancellation fee for missed appointments.***

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by our insurance. You may also choose a comfortable amount to be automatically billed to your Visa or MasterCard on a monthly basis.

As a courtesy to you, Alamo Springs Dental does its best to estimate your patient portion and file claims on your behalf. This is only an estimate and NOT a guarantee of payment until your insurance has finished processing the claim. You are fully responsible for any balances not paid by your insurance company. Treatment requirements and estimates are subject to change.

We are grateful for the opportunity to provide dental health care to you and your family.

Signature: ____ Date:______________________________

Updated: 11/2018

Alamo Springs Dental Privacy Practices
Your Information. Your Rights. Our Responsibilities.

Privacy Officer: Dr. Aiyana Anderson- 210-463-9339-11590, Alamo Springs Dental, Galm Rd. San Antonio, TX 78254
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and @ www.alamospringsdental.com

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. Paper copies: $10 Electronic are FREE

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-

877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions:

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, Share information in a disaster relief situation, Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases **we never** share your information unless you give us written permission: Marketing purposes, Sale of your information, Most sharing of psychotherapy notes

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you againn

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- We can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary
- We can use and share your health information to bill and get payment from health plans or other entities. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

1. **Help with public health and safety issues**

   We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety

2. **Respond to organ and tissue donation requests**

3. **Work with a medical examiner, coroner, funeral director when an individual dies.**

4. **Address workers' compensation, law enforcement, and other government requests:** We can use or share health information about you: For workers' compensation claims, law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services

5. **Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena. If state or federal laws require it we will share your information to comply with the law, including with the Department of health and human service if it wants to see if we are complying with federal privacy law.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.